E91

Hauora Tairāwhiti

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

ANNUAL REPORT 2020

Contents

Message from the Chair

Tuatahi, ka mihi atu ki tō tātou nei kaihangaia, nāna te timata, nāna te whakaoti ō ngā mea katoa. Tuarua, ki ngā tini aitua o te wā, kō rātou kua mene atu ki te pō, haere koutou ki ō mātua kī ō tīpuna e tātari ana mā koutou mē ō tātou nei matua nui i te rangi. Kō tātou nei e takatū tonu ana mā runga ī te whenua, hei urupā mō ngā moemoeā ō rātou kua wheturangihia, tēnā koutou, tēnā tātou.

Following the local body and DHB elections in October 2019, the Hauora Tairāwhiti Board was formally appointed in December 2019. I would like to thank previous members for their service to our community, those who were returned for their on-going commitment, and the many new members to the Board.

Undoubtedly, Covid-19 has been a consuming issue for our whole community. In the early days of the pandemic, data collected by John Hopkins University showed NZ was on the same trajectory as some of the worst affected countries in the Northern Hemisphere. This triggered a nationally driven response, with the Ministry of Health assuming national leadership given the extent of risk we were facing. The initial emphasis was on preparedness – gearing our health services to cope with a possible deluge of people with Covid-19 requiring hospital level care. If that trajectory had played out our health services would have been overwhelmed. Fortunately, our protective measures moving through the alert levels headed this risk off. And while we were as best prepared as possible, the quid pro quo was core health provision was seriously interrupted.

Locally, this demanded an urgent focus on reconfiguring the hospital to create separate pathways and care for patients potentially afflicted by Covid-19, establishing supply lines for critical supplies, establishing and equipping testing centres, supporting changes in primary care including shifting to telehealth and supporting the Covid-19 and on-going work of our iwi and community providers. Of note, the Tairāwhiti district has maintained one of the highest testing rates in the country, now second only to the DHBs that have elevated rates due to managing isolation facilities and the Auckland cluster.

Without a doubt, the combined efforts across our local health and social services sector, and the community as a whole, have protected us from what could otherwise have been a devasting outcome. I particularly want to acknowledge all of our essential workers - those in the health system, those who kept our supply lines and essential services open, those who manned community safety zones, those who provided support and care to the most vulnerable members of our community, those who ensured the safety of the community as a whole – ngā mihi ki a koutou. Most importantly, to our whole community who rallied during the most trying health challenge of our lifetime, ngā mihi ki a tātou katoa.

As we know, we are not yet done. Covid-19 still rages around the world, and it is critical that we remain ready for any further outbreaks, and maintain the necessary public health measures to minimise the impacts if any should occur. Alongside this, our attention is firmly fixed on catching up on those health services that were interrupted, and providing the best possible care we can to our community.

During the year, Te Manawa Taki, previously known as the Midlands Region, comprising Hauora Tairāwhiti, and the Taranaki, Bay of Plenty, Lakes and Waikato District Health Boards prepared its Regional Equity Plan 2020-2023. The vision of Te Manawa Taki is “He kapa kī tahi – a singular pursuit of Māori health equity”. Together, the five District Health Boards have committed to a system approach and range of actions to shift the dial on the disproportionately poorer health outcomes experienced by our Māori communities.

On a final note, the report on the Health and System Disability Review, led by Heather Simpson, was released in June of this year. The review team was charged with recommending changes to the health system that would be sustainable, lead to better and more equitable health outcomes for all New Zealanders, and shift the

balance from treatment of illness to health and wellbeing. The report's findings and recommendations are wide ranging, and we await the decisions of the incoming government on its implementation.

It was an honour to be appointed Chair of Hauora Tairāwhiti in December, and although somewhat busier than expected I have enormously enjoyed my early months in this role. My thanks to the Board, and Jim and the staff for their support, and for helping me to get grounded in this important work. We all look forward to the year ahead and continuing to provide the best possible care to the community.

Hēoi ano

Kim Ngārimu,

Board Chair
Hauora Tairāwhiti Board
18 December 2020

Message from the Chief Executive

In the same report as this 12 months ago I made the following comments about the year ahead.

"The biggest factor is going to be the quantum of the work we have to do. Not only will we be managing the demand and looking to improve health outcomes, we have notable projects such as completing a review of our Mental Health and Addictions services, planning for the build of a new Mental Health, Addictions and Rehab facility, re-defining our services for Older People, stepping up the pace in our Mokopuna Ora programme, reducing the admission of children to hospital, improving our matching of staff to demand, finally getting a new Clinical Workstation, seeing new buildings rise on our site for community partners, and living within our means. That is a lot. We are up for it though."

Nowhere in that was or could there be any inkling of the unprecedented event of a global pandemic and the response in our own country, plus here in Te Tairāwhiti. That event has had a massive effect and before going on to discuss what we did achieve there has to be full recognition once again of what we all have accomplished – the team of 5m, the team of 50,000 in Tairāwhiti, the team across the health system in Tairāwhiti and the team of 1,000 at Hauora Tairāwhiti.

COVID-19 has been an intense and anxious time in health and for the people in our community, with significant workloads and courage displayed by many. For most of us in health the days were about working out what was needed in the unknown new circumstances, and responding to what was coming at us. As Hauora Tairāwhiti we had a determination the perils of the last major pandemic (over 100 years ago) would not be repeated in our community. With that determination and teaming up with all our health providers, iwi and the community, collectively we got a really good outcome. From the Board Chair and Board, supported by the Director General and colleagues across the national and regional health system, right throughout the whole of Hauora Tairāwhiti and the wider sector here, everyone did their bit. It was humbling to see that response first hand and I know I express the gratitude of all for what was achieved. Thanks everyone.

So what about all those other projects we set out to achieve? Well, surprising as it may be in the circumstances, we have actually completed most of them.

We were managing demand well, before COVID-19 came along and demand stripped that away almost overnight. Our learnings from prior years and our work to improve the interface with primary care, bolstered services there over the winter and in the hospital at night, were showing you can flatten the growth of service demand. We must build on this in the year ahead.

We have been delayed though in our work to re-define services for older people. While our new model of care in the community for older people – the restorative model – has significantly reduced the need for older people to go in to residential care through increasing independence, we have not completed the review of how we can make our own services more effective. That is now underway and there will be a report and action plan before the end of 2020. We think we can make some real gains.

We have completed our review of Mental Health and Addictions services, just not released the findings yet. That will occur in September and will enable us to link the findings into our service improvement drive in those services, as well as our inequity elimination programme in 20/21. Our steering group and contactors worked remotely and via Zoom all through the lockdown to make sure our business case for the new Mental Health and Addictions facility was not delayed in submission. In fact we delivered ahead of time and this will enable us to get building ahead of time, before the end of 2021.

For children, there has been a further decline in the need for children to be admitted to hospital as our services and those of primary care and particularly the iwi providers have continued to improve effectiveness in supporting families in the community. The links with Manaaki Tairāwhiti and their programme of work have

undoubtedly had benefits in this regard. The significant increase in community based services such as 50 Families and Whāngaia Ngā Pā Harakeke mean increasingly children can live the lives they deserve and their families want to ensure. Our work as a DHB is even more inexorably intertwined with that of Manaaki Tairāwhiti and its iwi leadership. Our 20/21 plans take that many steps further with enhanced mental health and addictions services in the community being guided through the collective, the development of our child and youth hub which has been delayed, and our first ever specific equity investment plan made possible by the unprecedented increase in funding for the DHB. We have done well in the difficult circumstances of 19/20 to prepare for this.

Technology wise, we didn't implement our new clinical work station. We had to halt progress while we concentrated on COVID-19, but we are back on track now. We did however learn a very large amount about the use of technology in service provision. We have set ourselves up for a new future where far more of our services will be delivered by telehealth – because it is better in many situations, more efficient, and most of all, people like it because it meets their needs

Financially, our position actually got a bit better. It really isn't a good year to compare with the prior but if the effects of COVID-19 are removed our result for the year will be under budget. It is a long time since I have been able to report that. We had plans to implement in how we could control the ever increasing cost increases beyond our funding growth and in controlling demand, working smarter, in conjunction with our partners across the system, we have been successful. We have quite a different financial picture to work to in 20/21 with the deficit projected to be more than halved, built off the major increase in funding for the year. We will have to work hard to achieve that but we have funding to make that work, more than we have ever done before.

So 20/21 will be another year that is not like any other. There is a major list of projects we have signed up for, with our community partners such as Mātai and Hospice Tairāwhiti, our regional and national work and our special relationship with iwi. Our equity actions will be a particular feature. Substantial progress will be set in place and we will see delivery on that by the year end. Buildings will come down, buildings will go up. New services will be implemented by Hauora Tairāwhiti and we will fund more than ever. We will be scrutinised more and work even more on the wider determinants of health. Can't forget what might happen with the Simpson review, although we have to see what happens in September first. It is therefore going to be a year on a grand scale, and it is full on already.

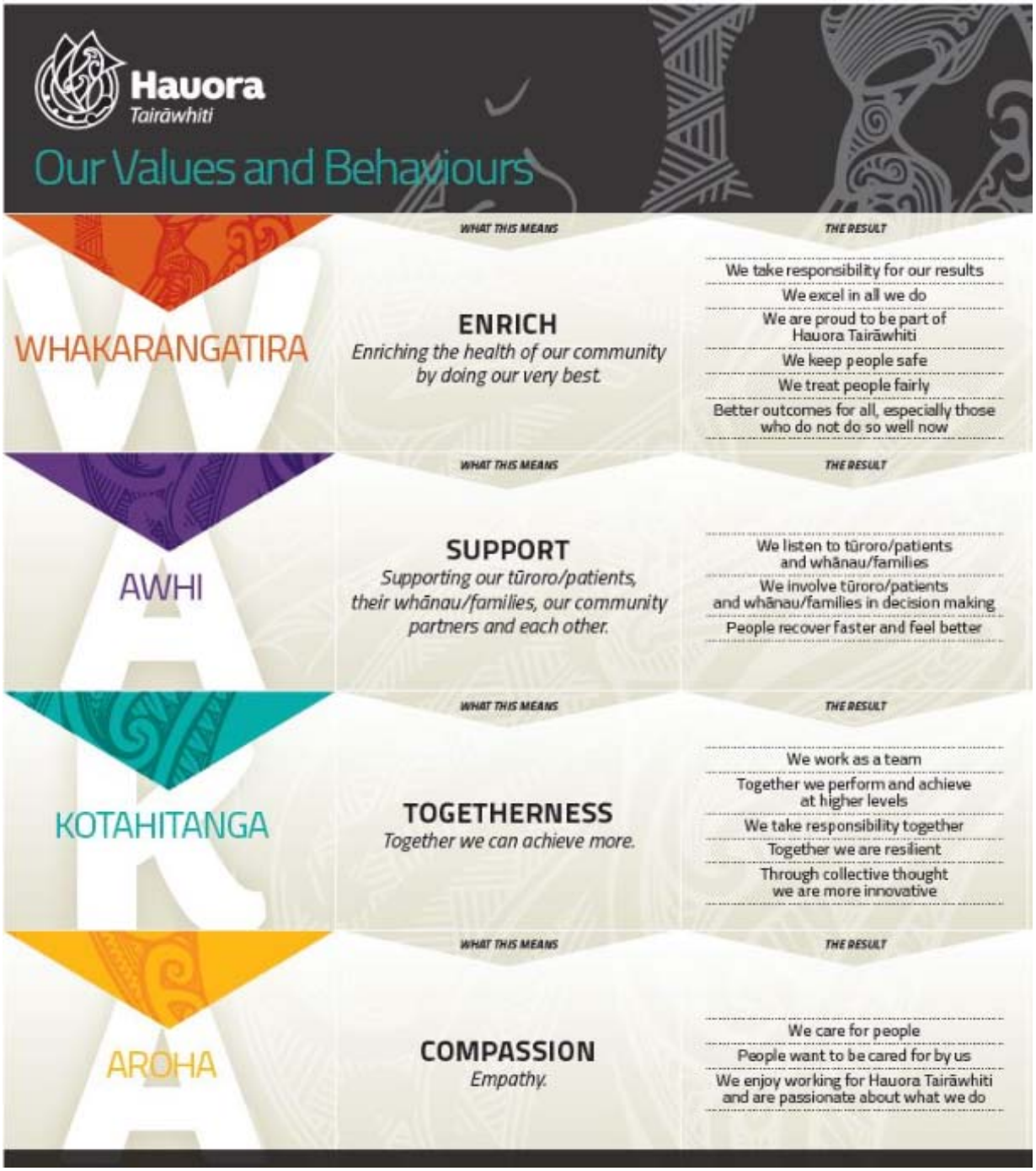
Jim Green

Chief Executive
Hauora Tairāwhiti Board
18 December 2020

Hauora Tairāwhiti DHB mission, values and behaviours

Our mission

Working together, to elevate the wellbeing of Tairāwhiti."
"Mahi a ngā mahi i roto i te kotahitanga kia piki ake te oranga o te Tairāwhiti.

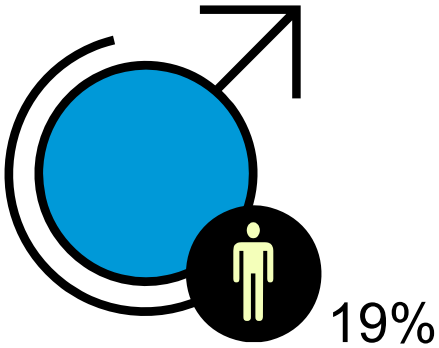


Our values form the acronym WAKA. They reflect our past while guiding us on our journey to create a healthier Tairāwhiti by working together.

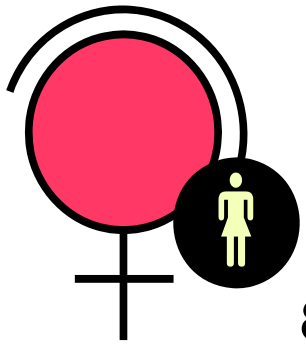
About Hauora Tairāwhiti

The DHB currently employs **1,070** people, a number of whom are multi-jobbed.

Of these **1,070** people:



19%



81%

WORKFORCE PROFILE – by age bands	
<25	5.0%
25 - 35	19.3%
35 - 45	18.9%
45 - 55	22.0%
55 - 64	24.7%
65+	10.3%

WORKFORCE PROFILE – by occupational group	
Medical staff	8.2%
Nursing staff	44.6%
Allied Health staff	21.8%
Non-clinical support staff	7.1%
Management & admin staff	18.3%

WORKFORCE PROFILE – by ethnicity	
NZ European	45.1%
NZ Māori	33.8%
Pacific Island	1.4%
British & Irish	3.6%
Other ethnicities	15.7%
Not known	0.3%

EMPLOYEE STATUS	
Casual	17.1%
Full time	39.9%
Part time	43.0%

Report on good employer obligations

Hauora Tairāwhiti understands that in order to continue to make good decisions and consistently perform as a good employer it is essential to actively grow leadership by identifying, nurturing and supporting staff to improve leadership competence and capability.

Staff in designated leadership roles have also been given the opportunity to grow their leadership capability by attending local and regional health leadership training. These learnings have been supplemented by locally facilitated shorter learning opportunities found on the learning and development calendar which have been well attended.

Over the past year, Hauora Tairāwhiti has hosted Midlands Leadership in Practice training and Midlands Advanced Leadership training for middle managers. This training was also opened to include other local public business management.

Both programs are supported by the five regional District Health Boards (Te Manawa Taki), which also allows for multi-disciplinary networking across the region.

A significant amount of work continues to be undertaken to strengthen working relationships with unions. Local bipartite meetings have been well attended and held regularly throughout the year. Tairāwhiti has been working with the unions to develop an annual work plan to ensure that there is proactive work happening outside of the meetings.

Recruitment, Selection and Induction

Hauora Tairāwhiti supports equal employment opportunities (EEO) through its recruitment practices by ensuring fairness, equity and transparency are applied when advertising and considering applications for employment. Tairāwhiti recognises the importance of diversity in the workplace and encourages practice to support ethnic minorities and recruiting applicants with disabilities. Extensive policy and process reviews have been completed to support the organisation in minimising the impact vacancies have on business performance.

Hauora Tairāwhiti integrates health checks and assessments into all of its recruitment processes to evaluate baseline health and how that can be supported through workplace and workstation setup. Recruitment processes have also been enhanced to include credit checks for employees that handle finances, introduced competency based questions, conflicts of interest, and more rigorous screening of staff that are working with vulnerable people, including children and the elderly in line with the Vulnerable Children's Act (VCA).

Recruitment training has been made available throughout the year to recruiting managers to support best practice. Māori representation is also a requirement for all recruitment panels. To ensure there is an equal opportunity to apply for roles, all vacancies are advertised through Kiwi Health Jobs (KHJ) and the Hauora Tairāwhiti website. The DHB owned KHJ site attracts over 60,000 job seekers per month.

Māori Workforce Planning

There has been a significant body of work completed to engage and connect with our Māori community in order to reduce health inequities and grow the Māori workforce representative of our community. There has also been a targeted approach to promote health to ethnic minorities including Māori and working alongside Te Manawa Taki (formerly Midlands Region) regional Kia Ora Hauora (KOH) coordinator to tailor the messaging and promotional material toward Māori and whānau.

Hauora Tairāwhiti continues to support a bi-cultural induction and on-going training by providing all staff with a powhiri and training in tikanga best practice. The new employee orientation day has been restructured to increase attendance and understanding. All Hauora Tairāwhiti staff have received the opportunity to attend training by our kaumatua specific to the WAKA values, which is an ongoing feature on the learning and development calendar.

Employee Development, Promotion and Exit

Hauora Tairāwhiti has a fair and equitable performance appraisal system in place, called 'You Time', which is supported by our policies. The Employment Relations Act, and Health and Safety Act continue to reinforce the need to maintain strong relationships with employees and unions. The Bipartite Union Committee continues to be the forum for union delegates to be engaged on the Transform and Sustain agenda to discuss common issues. Learning needs and career aspirations are identified through the appraisal tool 'You-Time' which are then supported through on job training, projects, courses, sabbaticals and study.

All staff have access to the learning opportunities offered through the learning and development calendar. The Hauora Tairāwhiti learning facility Ko Matakerepo supports staff development, which includes a lecture room, two video suites, computer lab and library. Where possible, learning opportunities have been made available to community based organisations and contractors who work within the Tairāwhiti community.

Hauora Tairāwhiti continues to support the 'grow our own strategy' which focuses on developing and promoting talent from within the organisation. Secondments, projects, acting-up opportunities and fixed term positions are widely promoted to staff to provide the hands on experience and pay incentives to staff readying them for promotion opportunities when they become available. This includes development as identified above others designed to develop coaching skills, for example the "Coaching Clinic".

Staff departing the organisation are encouraged to complete an exit survey.

Hauora Tairāwhiti has an on the job learning programme for newly graduated nurses called the 'Nurse Entry to Practice' programme (NETP) that supports graduate nurses through the beginning stages of their career. The programme supports Tairāwhiti graduates that have come through the local polytechnic provider and offers a safe working environment that grows new graduates into competent registered nurses. Hauora Tairāwhiti supported extra graduate nurses into the programme over the past 12 months to accommodate the extra numbers graduating.

Flexibility and Work Design

Hauora Tairāwhiti recognises how important it is to continually support the changing demands of life and support work life balance where that does not compromise care. The 'You Time' appraisal template includes a section where staff can discuss how their changing circumstances may be supported by Hauora Tairāwhiti, such as reducing hours of work to support early retirement or being available for young children. The social needs of staff are also considered when designing rosters. This year has also seen a need to adapt and think outside the box to support staff and changing needs to meet the ever changing COVID-19 scene. This added a new dimension on working remotely where applicable.

Remuneration, Recognition and Conditions

The majority of staff are employed under multi-employer collective agreements, which are negotiated nationally. The DHB and unions ensure that remuneration in the health sector is fair and equitable based on the affordability of the health system. Hauora Tairāwhiti continues to use the Strategic Pay methodology to job evaluate roles for staff on individual employment agreements.

Harassment and Bullying Prevention

Hauora Tairāwhiti does not accept harassment and bullying in the workplace. Hauora Tairāwhiti has been undertaking a number of initiatives to embed appropriate behaviours in the workplace and to reduce the prevalence of unwanted behaviours that include harassment and bullying. This has included the launch of behaviours that underpin the WAKA values and supporting services to embed appropriate behaviours, and develop processes to safely call inappropriate behaviours and foster safe working cultures.

Safe and Healthy Environment

Hauora Tairāwhiti as a good employer provides a safe and healthy working environment and offers support to staff via an Employee Assistance Programme. This programme is available to staff who may be facing issues either at home or within the workplace that may affect their performance at work.

Governance Philosophy

Connection with Stakeholders

The Board acknowledges its responsibility to keep in touch with stakeholders and, in particular, remain cognisant of the Minister of Health's expectations.

Division of Roles between the Board and Management

The efficient running of Hauora Tairāwhiti requires a clear division between the roles of the Board and Management. The Board concentrates on setting policy, approving strategy, and monitoring progress towards meeting objectives. Management is concerned with implementing policy and strategy. The Board has clearly distinguished these roles by ensuring that the delegation of authority to the CE is concise and complete as delineated in the approved delegation policy.

Accountability

The Board holds meetings most months and monitors progress toward its strategic objectives. The Board also ensures Hauora Tairāwhiti actions and those of its subsidiary and associates adhere to Hauora Tairāwhiti policies.

Members' Interests

The Board maintains an Interests Register and ensures members are aware of their obligations to declare any interests they may have in matters under consideration by the Board or in the wider operations of Hauora Tairāwhiti.

At least on an annual basis, or as interests arise, the CE and direct reports to the CE are required to make a declaration of interests, which the Board Chair reviews for any conflicts, with associated management strategies put in place. These interests are also reported to the Board.

Internal Audit

Overall responsibility for maintaining effective systems of internal control ultimately rests with the Board. Internal controls include the policies, systems, and procedures established to provide assurance that specific objectives of the Board are achievable, and that reporting to the Board is reliable. The Board and Management have acknowledged their responsibility by signing the Statement of Responsibility which can be found on page 42 of this report. Hauora Tairāwhiti contracts an Internal Audit function through the Internal Audit division of Health Share, which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non-financial information reported to the Board. Internal Audit operates independently of management and reports its findings directly to the Board's FRAC Committee, which in turn reports any issues or concerns to the Board. Internal Audit liaises closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

Risk Management

The Board acknowledges that it is ultimately responsible for the management of risks to Hauora Tairāwhiti. The Board has charged the CE, through its Risk Management Policy, with establishing and operating a risk management programme in accordance with the "Guidelines for Managing Risk in the Australian and New Zealand Public Sector SAA/NZSHB 143:1999". The FRAC committee receives three monthly reports on the risk management programme.

Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all legislation. The CE has delegated authority from the Board to develop and operate a programme that systematically identifies compliance issues and ensures staff awareness of legislative requirements that are particularly relevant to them. The FRAC committee receives a quarterly report on the legislative compliance programme.

Governance and Accountability Statement

Tairāwhiti DHB is a crown entity, established on 1 January 2001, responsible for funding, providing, and ensuring the provision of personal health, mental health and Māori health services to the resident population of the district and disability support services for residents over 65 years of age. In 2015, Tairāwhiti DHB was rebranded to Hauora Tairāwhiti as the organisation signalled a change in how people access health services and how this can be improved, specifically in equity of health outcomes for Māori.

Hauora Tairāwhiti's role is three fold, namely Owner/Governance, Funder, and Provider of public health and disability services in the district.

The Funding arm, Te Puna Waiora (Spring of Wellness), leads the process of assessing the needs and planning for the services required by the people of Tairāwhiti. The team administers the agreements generated through the funding process. This includes the funding of all personal health, mental health, Māori health and disability support services for people over the age of 65 for the Tairāwhiti population. Te Puna Waiora also has a monitoring and auditing function in most part carried out through HealthShare, Te Manawa Taki's Shared Services Agency.

The Provider arm, is the principal Provider of secondary health and disability services to the people of Tairāwhiti. These services include medical, surgical, women's health, child health, elderly, disability support, mental health, public health, and related support services.

Hauora Tairāwhiti also accesses health services for the people of Tairāwhiti from organisations outside the district, primarily through referrals to Waikato Hospital and Auckland Starship for tertiary services, and Wellington for other specialist services.

Role of the Board

Under Section 25 (1) of the Crown Entities Act 2004 (the CE Act), the Board is the governing body of Hauora Tairāwhiti, with the authority, in the DHB's name, to exercise the powers and perform the functions of Hauora Tairāwhiti. Under section 25 (2) of the CE Act, all decisions relating to the operation of Hauora Tairāwhiti must be made by, or under the authority of, the Board in accordance with the CE Act and the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).

The focus of the Board is on governance and policy issues. The Board's primary responsibilities are:

- Representing the 'owner' (the Crown)
- Setting strategic direction and policies for Hauora Tairāwhiti
- Appointing and resourcing the CE
- Delegating responsibility to the CE and monitoring the CE's performance
- Monitoring the implementation and performance of plans that will have a significant effect on the DHB
- Ensuring compliance with the NZPHD Act, the CE Act and all other relevant legislation
- Fostering community participation in health improvement, including participation by Māori.

The people of Tairāwhiti elected seven members to the Board in October 2019. The Minister of Health appointed a further four members to form the governing Board. All Board members are required to act in the best interests of Hauora Tairāwhiti. Members acknowledge that the Board must stand unified behind its decisions; individual members have no separate governing role outside the boardroom.

Profile of the Board

The Board carries out its governance role through regular formal meetings and through associated subcommittees. The Board has a partnership relationship with each of the iwi in Tairāwhiti. It also has a Caucus Accord with local Māori representing iwi, Māori providers, and Māori organisations, through Te Waiora o Nukutaimemeha Māori Relationship Board. A partnership relationship also exists with the Pacific Islands Community Trust.

Directory

Board Members	
David Scott (Chair)	Appointed, June 2010 Reappointed, December 2010 Reappointed, December 2013 Reappointed, December 2016
	Term Ended December 2019
Geoff Milner (Deputy Chair)	Appointed, December 2010 Reappointed, December 2013 Reappointed, December 2016
	Term Ended December 2019
Brian Wilson	Elected, October 2007 Re-elected, October 2010 Re-elected, October 2013 Re-elected, October 2016
	Term Ended December 2019
Kathy Sheldrake	Elected, October 2010 Re-elected, October 2013 Re-elected, October 2016
	Term Ended December 2019
Rehette Stoltz	Elected, October 2013 Re-elected October 2016
	Term Ended December 2019
Meredith Akuhata-Brown	Elected, October 2016 Re-elected December 2019
Josh Wharehinga	Elected, October 2016 Re-elected December 2019
Hiki Pihema	Elected, October 2016 Re-elected December 2019
Prue Younger	Elected, October 2016
	Term Ended December 2019
Gavin Murphy (Deputy Chair)	Appointed, December 2016 Re-appointed December 2019
Na Raihania	Appointed, December 2016
	Term Ended December 2019
Kim Ngarimu (Chair)	Appointed December 2019
Robyn Rauna	Appointed December 2019

Amy Wray	Appointed December 2019
Andy Cranston	Elected December 2019
Sandra Faulkner	Elected December 2019
Tony Robinson	Elected December 2019
Heather Robertson	Elected December 2019

Corporate Office

Hauora Tairāwhiti
Private Bag 7001
421 Ormond Road
Gisborne 4040

Auditor

Audit New Zealand
For and on behalf of the Auditor General

Solicitors

Nolans
Gisborne

Chapman Tripp
Auckland

Transactional Bankers

Bank of New Zealand
Gisborne

Identifiers

GST Number	61-243-240
NZ Business Number	9429000097956

Board Members Register of Interests

The following are particulars of entries in the Interest Register made by Board members for the period between 01 July 2019 and 30 June 2020.

Report of Permissions under Section 68(6) of the Crown Entities Act 2004.

Board Member	Transaction / Matter	Conflict Arising	Nature of Conflict/s	Board Response / Action
Aug-19				
Brian Wilson	Item 12.1 (HAC) Reallocation of Gisborne Hospital services	In relation to his role as a Hauora Tairāwhiti Director of Tlab	Savings expected to be derived from the reallocation of Gisborne Hospital services	The Board agreed the member could stay for discussion and decision.
Feb-20				
Gavin Murphy	Item 12.1 (Board) Facilities Update	In relation to his role as Trust Tairāwhiti Chief Executive	Funding a study of feasibility of Chelsea onsite	Mr Murphy excused himself from this discussion.
Jun-20				
Gavin Murphy	Mātai Lab Presentation (Board)	In relation to his role as Trust Tairāwhiti Chief Executive	Trust Tairāwhiti is a funder of Mātai Lab	The Board agreed the member could stay for discussion and decision.

Role of the Chief Executive

The Board has appointed a single employee, the Chief Executive (CE), to manage all DHB operations. The CE has appointed all other employees of Hauora Tairāwhiti. The Board directs the CE by delegating responsibility and authority for the achievement of objectives through setting policy.

The Board delegates to the CE, on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the Board's agreed strategic direction as set out in the Annual Plan. It endorses the CE, assigning defined levels of authority to other specified levels of management within the organisational structure.

Statutory Advisory Committees

The Board Advisory Committees, including those Statutory Committees required under the NZ Public Health and Disability Act 2000, were set up to provide a more detailed level of focus on particular issues. The committees have delegated authority for governance to action the Board's policies as well as monitoring the organisation's progress towards meeting Hauora Tairāwhiti's objectives. The committees also have formal budgetary delegations to fund services or approve expenditure on Hauora Tairāwhiti's behalf. The Board's standing committees (including the statutory permanent advisory committees) are:

Committee:

- Finance, Risk & Audit (FRAC) – Monthly
- Hiwa I Te Rangi (Advisory Committee) - Monthly
- Te Waiora o Nukutaimemeha Iwi Relationship Board – Monthly
- Staffing & Governance Committee (S & G) - Quarterly or as required

Advisory Committee Members

The Committees include, in addition to selected Board members, representatives from the Tairāwhiti community selected through an application process.

BOARD/Committee	Board Member (interim) until 30 June 2020	Community Members until 30 June 2020
Hauora Tairāwhiti Board	**Kim Ngarimu (Chair)** Gavin Murphy (Deputy Chair) Robyn Rauna Amy Wray Andy Cranston Sandra Faulkner Tony Robinson Hiki Pihema Josh Wharehinga Meredith Akuhata-Brown Heather Robertson	n/a
Finance, Risk & Audit Committee (FRAC)	Heather Robertson (Chair) Gavin Murphy Tony Robertson Robyn Rauna Meredith Akuhata-Brown Kim Ngarimu (ex officio)	John Hockey
Hiwa I Te Rangi (Advisory Committee	Josh Wharehinga (Chair) Hiki Pihema Amy Wray Andy Cranston Kim Ngarimu (ex officio)	Te Aturangi Nepia-Clamp Na Raihania
Te Waiora o Nukutaimemeha	Josh Wharehinga Kim Ngarimu (ex officio)	Na Raihania (TRONP)/Chair Molly Para Lois McCarthy-Robinson Whiti Timutimu Angus Ngarangioue (TROTAK) Tomairangi Chaffey-Aupouri Te Aturangi Nepia-Clamp Māori Health Provider representative
Staffing/Governance	Kim Ngarimu (Board Chair) Heather Robertson (FRAC Chair)	n/a
TLab Directors	Gavin Murphy (as at 1 April 2020) Craig Green (as at 1 April 2020)	n/a
Tairāwhiti Laundry Services Ltd	Kim Ngarimu (as at 1 April 2020) Tony Robinson (as at 1 April 2020)	n/a

Quality Improvement

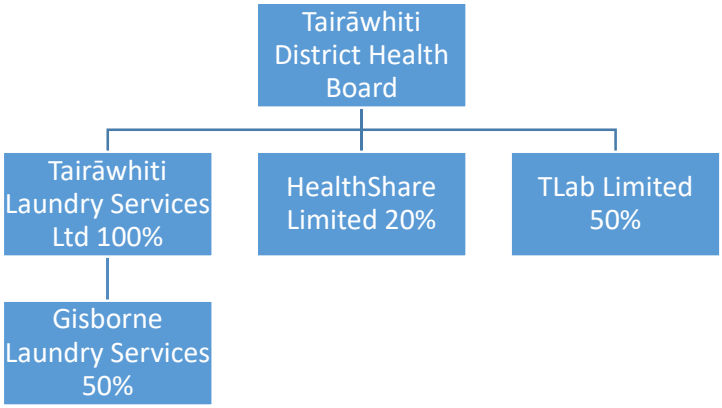
The Clinical Governance Committee oversees the quality improvement environment at Hauora Tairāwhiti reporting through the Chief Executive to the Board on patient safety matters and clinical quality improvement. Through these mechanisms, the Board guides the overall setting of the Hauora Tairāwhiti Quality Plan.

It is important to note that the Quality Plan for Hauora Tairāwhiti extends beyond its own provider services to include the operation of the funding arm and the activities of providers with agreements with Hauora Tairāwhiti.

The monitoring and audit plan for Hauora Tairāwhiti, completed in conjunction with HealthShare and the Ministry of Health's Sector Services, follows the quality improvement activity of providers. Reporting to the Board of audits for these providers is made through the FRAC Committee for overview.

Subsidiaries and Associates

Group Organisational Structure



Tairāwhiti Laundry Services Limited (TLSL)

TLSL (registered under the Companies Act 1993) is a wholly owned subsidiary of Hauora Tairāwhiti and is the holding company for its 50 percent investment in the Gisborne Laundry Services Partnership.

Gisborne Laundry Services (GLS)

GLS is a partnership between TLSL and Mahia Resort Limited that provides laundry services to Gisborne Hospital, its associated services, and other commercial laundry services to external customers.

Health Share Limited (HSL)

HSL (registered under the Companies Act 1993) is Te Manawa Taki DHBs' shared services agency, which is owned in equal shares by the five DHBs of Te Manawa Taki Region. The company provides specialist audit services to DHBs, other support service roles in areas such as internal audit, workforce development, regional planning and clinical network coordination, where this improves the effectiveness of DHB operations.

TLab Limited (TLab)

TLab Ltd (registered under the Companies Act 1993) is the 50/50 joint venture company between Hauora Tairāwhiti and MedLab Central Ltd, which provides laboratory services at Gisborne Hospital and for the wider Tairāwhiti community. The Company was established on 1 September 2007.

Statement of Performance

We present you here the results for the measures and standards as provided in our Statement of Performance Expectations.
To perform our functions well the actions we take must:

- Help deliver our outputs
- Make the impacts we intend
- Contribute to the achievement of our outcomes

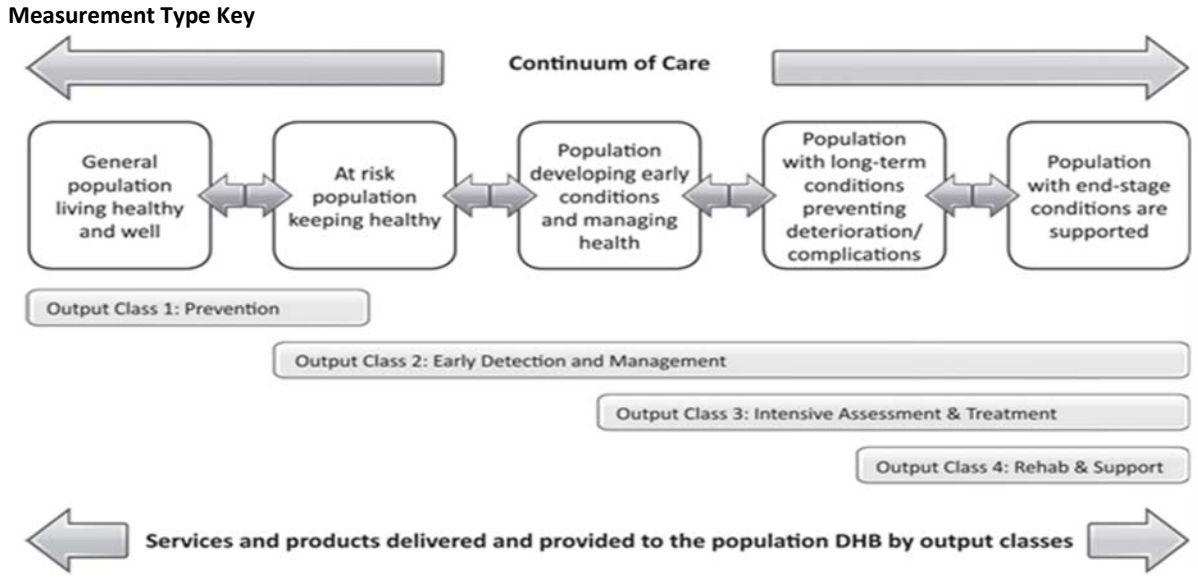
The measures chosen are a mixture of indicators of quantity, quality and timeliness in our priority areas. The measures and targets are outlined in our Statement of Performance Expectations for 2019/20[1] with the following section presenting the results achieved against the identified targets.

Structure of this section

The map on the next page shows the linkages between the 4 output classes below and four high level outcomes for Hauora Tairāwhiti. By including short term, medium term and long term measures linking high level outcomes and output classes we can demonstrate clear pathways to improving the health of Tairāwhiti.

Output Classes

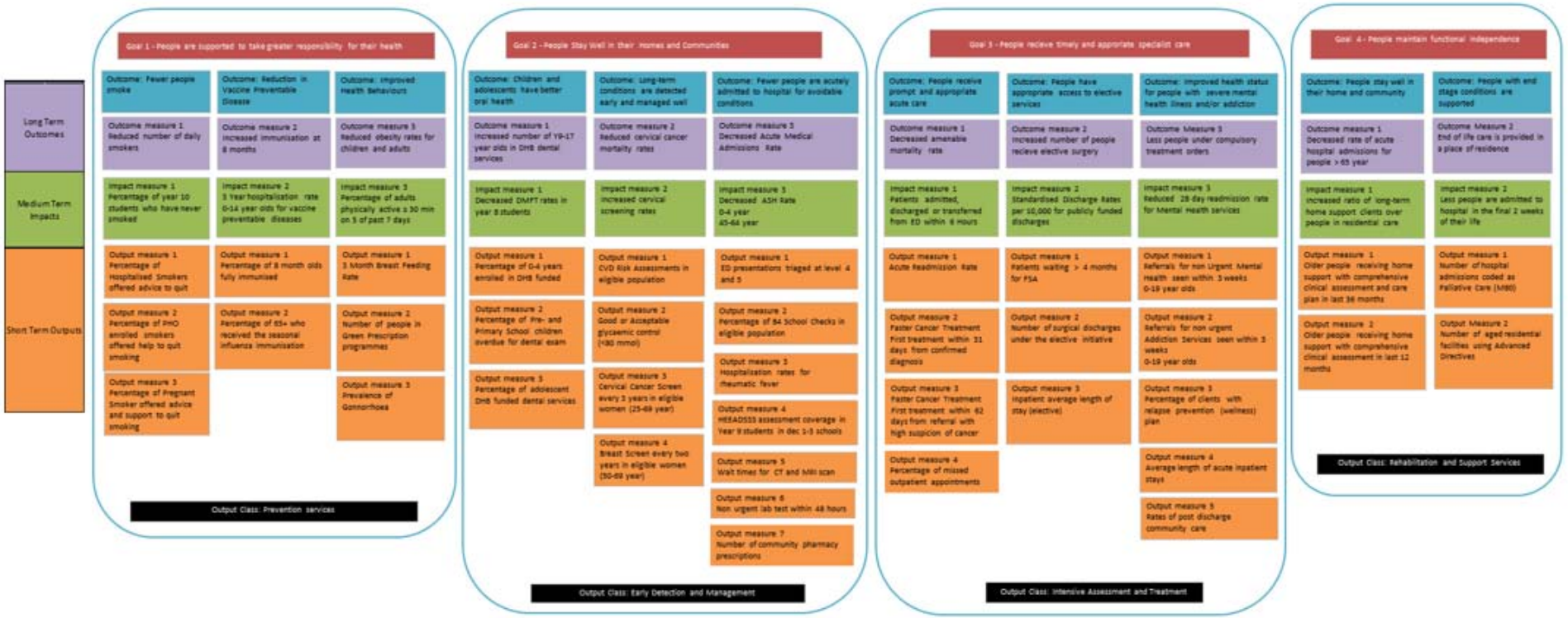
Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of performance expectations are also reflected in our financial measures. The four output classes that have been agreed nationally are described below. They represent a continuum of care, as follows:



Symbol	Definition
Ω	Measure of Quality
τ	Measure of Timeliness
δ	Measure of Quantity

[1] The statement of performance expectations is published in our 2019/2020 Annual Plan : https://www.hauoratairawhiti.org.nz/news-and-events/publication-and-consultation-documents/published-documents/annual-plan/

Map of Indicators



2019/20 Performance Overview

The results displayed in the following section are reflective of the dedication of staff throughout all areas of the health system in Tairāwhiti. Each of the indicators below relies on input from primary, secondary and community health providers and aspects working together.

Output class: PREVENTION SERVICES

Preventative health services promote and protect the health of our population by improving physical and social environments and supporting people to make healthier choices. These services include education programmes to raise awareness of risk behaviours, legislation and policy to protect people from environmental risks, and health protection services such as immunisation and lifestyle programmes that support people to modify their lifestyles and maintain good health. Success is defined by positive changes in behaviours and high coverage levels, which signal engagement in programmes and the effectiveness of positive health messaging and the quality of the support and advice being provided. We know however this is a long process that needs maintained effort to reach long term results.

Goal 1 – People are supported to take greater responsibility for their health

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions

Tobacco smoking, poor nutrition, inactivity and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

2019/20 Prevention Services Performance

Compared to 2018/19, 2019/20 saw a decrease in the number of young children admitted to hospital for vaccine preventable diseases. This follows the longer trend of the five years prior to 2018/19. Immunisation coverage for childhood vaccination decreased in 2019/20 largely due to the impact of the COVID-19 pandemic but it is expected that the coverage rate will increase in 2020/21 with children not fully immunised at the milestone stages in 2019/20 in a catch up programme. Due to the COVID-19 pandemic, extra effort was put into increasing influenza coverage for those 65 and over in 2019/20, this saw an increase of 9% in overall coverage with 63% of those 65 and over being immunised against influenza.

Overall brief advice to quit offered to smokers fell in 2019/2020. The notable exception to this was for hapu Māori wahine who smoke where the rate increased to 98% offered brief advice. Reducing smoking remains a focus area for Hauora Tairāwhiti as indicated in the 2018 Census the rates of daily smokers in Tairāwhiti is the highest across New Zealand.

OUTCOME MEASURES - Long Term[2]

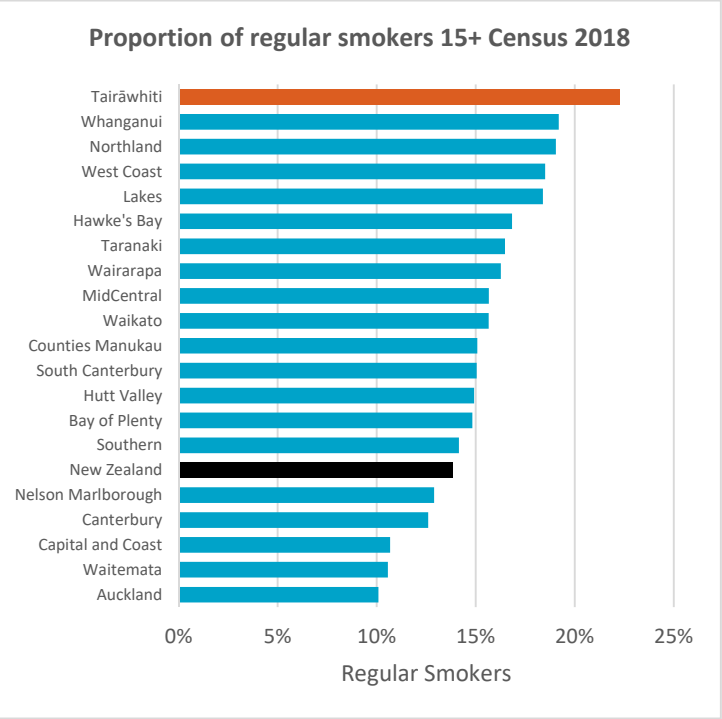
Outcome: Fewer people smoke

Tobacco smoking kills an estimated 5,000 people in NZ every year and is a major risk factor for six of the eight leading causes of death worldwide. Smoking is also a major contributor to preventable illness and long-term conditions, such as heart and respiratory disease and cancer.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity not only to improve overall health outcomes but also to reduce inequities in the health of our population.

Outcome measure 1: Reduced number of daily smokers



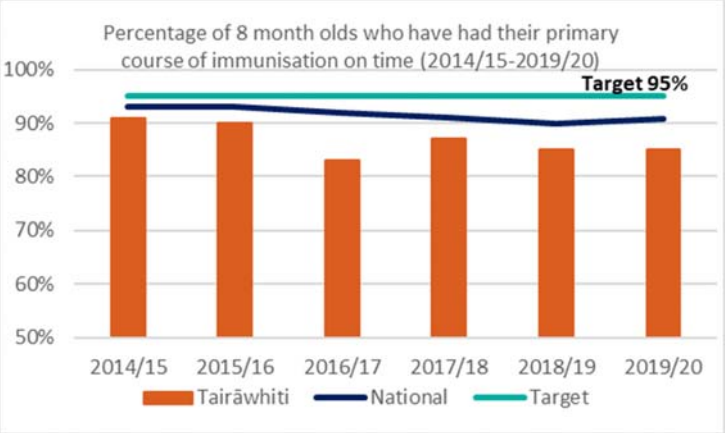
Data source: Census 2018 – Tatairanga Aotearoa (Stats NZ), April 2020

Outcome: Reduction in Vaccine Preventable Disease

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Tairawhiti	91%	90%	83%	87%	85%	85%
National	93%	93%	92%	91%	90%	91%
Target	99%	99%	99%	95%	95%	95%

Outcome measure 2: Increased immunisation at 8 months (HT)



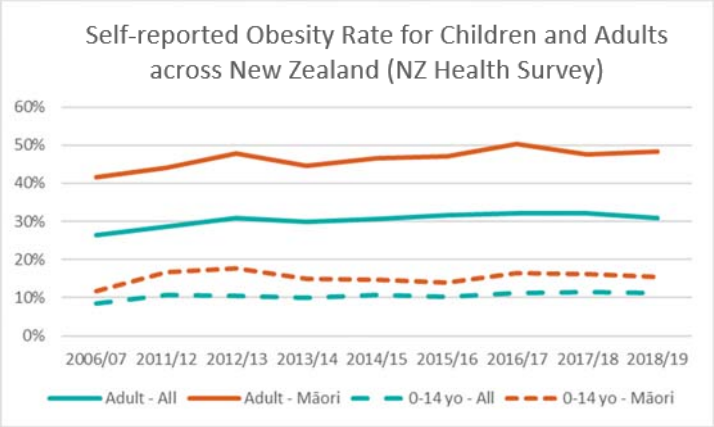
Data Source: Health Targets 2019/20

[2] Other entity information is unaudited

Outcome: Improved Health Behaviours

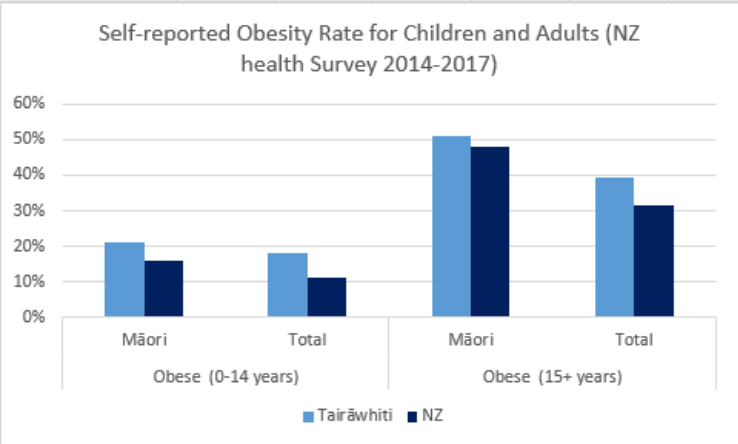
Good nutrition is fundamental to health and prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year. We aim for a reduction in obesity, a proxy measure of successful health promotion and engagement, and a change in the social and environmental factors that influence people to make healthier choices.

Outcome measure 3: Obesity Rates for Children and Adults decrease



Data Source: The 2018-19 NZ Health Survey, Dec 2019

Data Source: The 2018-19 NZ Health Survey, Dec 2019



Data Source: The 2016-17 NZ Health Survey, March 2018[3]

[3] Regional data from the survey has not been released since March 2018 for the 2016/17 year

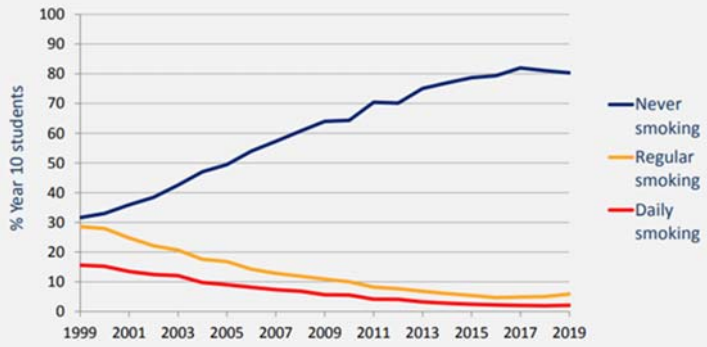
IMPACT MEASURES – Medium Term[4]

Outcome: Fewer People Smoke

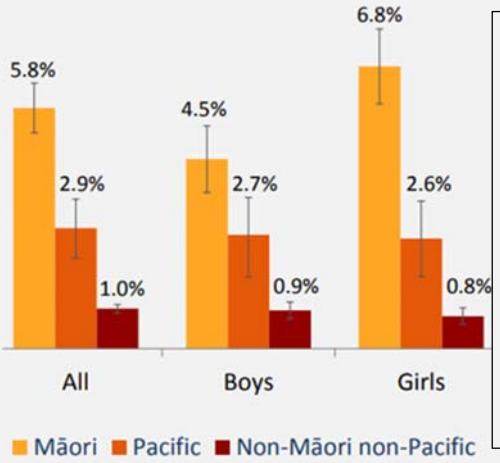
We see the highest prevalence of smoking among younger people, so preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population. Because the Māori and Pacific population groups have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles. Although no local figures have been published since 2015, national figures for 2018 show smoking in Māori and Pacific youth remains disproportionally high, with the highest daily smoking rates for Māori girls.

Impact measure 1: Percentage of year 10 students who have never smoked



Data Source – ASH New Zealand 2019. National Year 10 ASH Snapshot Survey.[5]



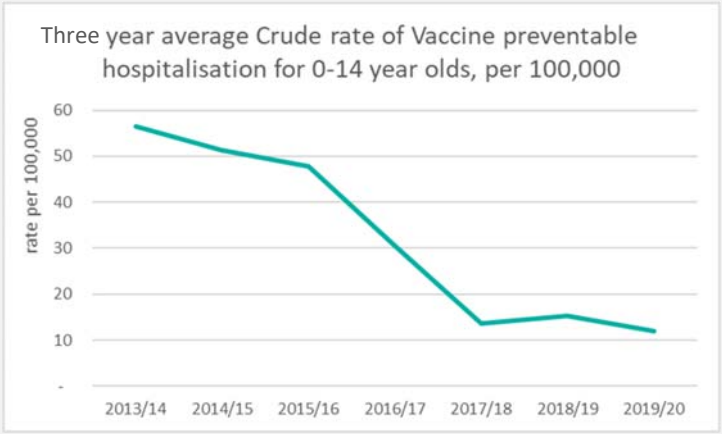
Daily smoking rates for Māori and Pacific students are markedly higher than for participants of other ethnicities (non-Māori non-Pacific). In 2019 daily smoking rates for Māori students are over 5 times higher than for non-Māori non-Pacific, with Māori girls reporting the highest daily smoking rates.

Outcome: Reduction in vaccine preventable diseases

Population benefits only arise with high immunisation rates (herd immunity) and New Zealand's historical rates were low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough).

Year	*Tairāwhiti*	*Midland region*	*New Zealand*
15/16	*47.86*	*34.97*	*31.41*
16/17	*30.57*	*38.04*	*25.10*
17/18	*13.52*	*No Regional/National Data Available*	
18/19	15.25		
19/20	11.90		

Impact measure 2: Three year hospitalisation rate for 0-14 year olds for vaccine preventable diseases



Data Source :National Minimum Data Set

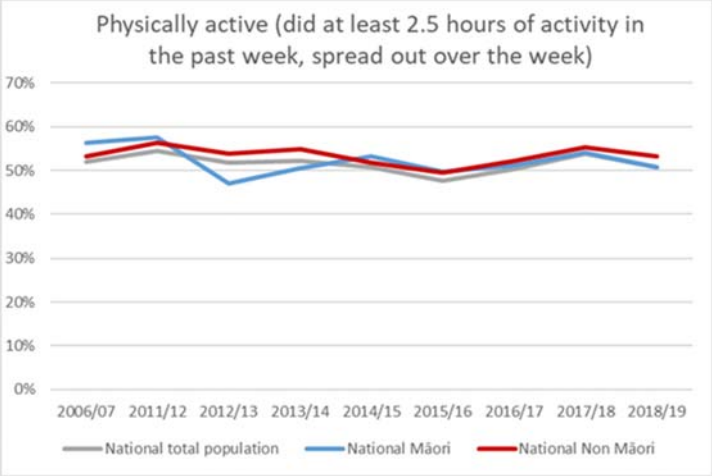
[4] Other entity information is unaudited

[5] No ASH Year 10 survey was undertaken in 2020 due to COVID-19

Outcome: Improving health behaviours

People gain weight when they consume more energy than they use. What a person eats and drinks, and how much activity they do directly affects their weight. But physical activity is beneficial in many other ways as well. People feel fitter, have more energy, and report improved sleeping quality and lower stress levels. The Ministry of Health recommends people aim for at least two and a half hours of physical activity a week. Improvements in physical activity levels and diets will lead to reductions in obesity levels.

Impact measure 3: Percentage of adults physically active for 30 minutes or more on 5 of past 7 days



Source - NZ Health Survey, December 2019[6]

OUTPUTS – Short Term Performance Measures

Outcome: Fewer people smoke

Outcome Measure		Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of hospitalised smokers offered advice to quit	Māori	δ	96%	94%	≥95%	92%	N/A	🡻
	Non Māori	δ	94%	92%		91%		🡻
	Total Pop	δ	95%	93%		92%		🡻
Percentage of PHO enrolled smokers offered help to quit smoking by a health care practitioner in the last 15 months (SLM) (PH04)	Māori	δ	85%	82%	≥90%	72%	78%	🡻
	Non Māori	δ	90%	90%		79%	80%	🡻
	Total Pop	δ	88%	84%		80%	80%	🡻
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered advice and support to quit smoking (PH04)	Māori	δ	92%	96%	≥90%	98%	N/A	🡹
	Non Māori	δ	100%	100%		88%		🡻
	Total Pop	δ	93%	96%		97%		🡹

[6] Previously reported as High Needs

Outcome: Reduction in Vaccine Preventable Disease

Indicator		Measure Type	2017/18 Result	2018/19 Result	2018/19 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of 8 month olds fully immunised (Health Target, SLM) (12 months figure) (CW05)	Māori	**τ/ δ**	83%	84%	**≥95%**	83%	84.3%	↓
	Non Māori	**τ/ δ**	89%	88%		90%	92.9%	↑
	Total Pop	**τ/ δ**	85%	85%		85%	91%	→
Percentage of 24 month olds fully immunised (12 months figure) (CW05)	Māori	**τ/ δ**	88%	84%	**≥95%**	92%	87%	
	Non Māori	**τ/ δ**	87%	85%		86%	93%	
	Total Pop	**τ/ δ**	88%	84%		88%	91%	
Percentage of five year olds fully immunised (12 months figure) (CW05)	Māori	**τ/ δ**	89%	89%	**≥95%**	90%	86%	
	Non Māori	**τ/ δ**	91%	88%		91%	90%	
	Total Pop	**τ/ δ**	90%	89%		90%	89%	
Percentage of girls and boys fully immunised against HPV (CW05)[7]	Māori	**τ/ δ**	82%	80%	**≥75%**	61%	59%	↓
	Non Māori	**τ/ δ**	73%	52%		59%	61%	↑
	Total Pop	**τ/δ**	81%	69%		61%	60%	↓
Percentage of people >65 years who have received the seasonal influenza immunisation (CW05)	Māori	**δ**	46%[8]	49%	**≥75%**	59%	67%	↑
	Total Pop	**δ**	53%	54%		66%	63%	↑

Outcome: Improving Health Behaviours

Indicator		Measure Type	2017/18 Result	2018/19result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of infants who are exclusively/fully breastfed at 3 Months (CW06)[9]	Māori	**δ**	40%	36%	**≥70%**	45%	47%	↑
	Non Māori	**δ**	66%	60%		66%	61%	↑
	Total	**δ**	51%	48%		56%	59%	↑
Raising healthy kids Percentage of obese children identified in the B4 School Check Programme who are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions (HT, CW10)	Māori	**δ**	89%	97%	**≥95%**	87%	97%	↓
	Non Māori	**δ**	100%	100%		78%	96%	↓
	Total Pop	**δ**	92%	97%		85%	96%	↓

[7] 2017/18 and 2018/19 reflects coverage for girls only as vaccine was only offered to them at this time

[8] Previously reported as High Needs

[9]Growing up in New Zealand 2017. http://www.growingup.co.nz/en/news-and-events/news/news-2017/new-research-gives-unique-insight-into-breastfeeding-in-new-zeal.html

Output class: EARLY DETECTION AND MANAGEMENT SERVICES

Early detection and management services support people to better manage their long-term conditions and avoid complications, acute illness and crises. By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increase in access to diagnostics and agreed referral pathways, and reductions in avoidable hospital admissions also reflect improvement.

Goal 2 - People stay well in their homes and communities

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease through education, screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the care path, particularly in improving the management of care for people with long-term conditions.

A range of other health professionals support primary care including midwives, community nurses, social workers, aged residential care providers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes against a lower cost than countries with systems that focus on specialist level care.

2019/20 Early Detection and Management Services Performance

The uptake of children in the DHB oral health enrolment continues to be in well above target, but the impact of the COVID-19 pandemic resulted in a slight increase in those overdue for the scheduled examination, but the target was still achieved. Coverage in adolescence remains an issue with half of those covered having treatment completed in the period, this is a focus area in 2020/21 where plans to address the uptake in rural areas expected to show results in the latter half of the year.

As with most risk reduction interventions the rates of cardiovascular risk assessments, breast and cervical screening, HEEADSSS assessments and B4School checks were impacted by the COVID-19 pandemic with rates falling in all areas. While most of these will be caught up in the first half of 2020/21, the rate of HEEADSSS is likely to prove more problematic but will be well in advance of reported coverage by the end of the academic year.

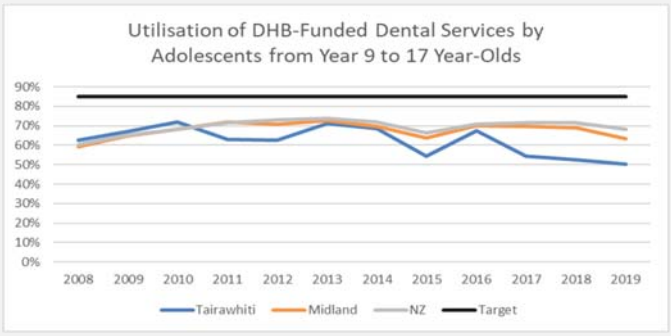
The progress on eradicating rheumatic fever from the community continues and further decreases may have been seen if it had not been for the COVID-19 pandemic response. The response saw additional overcrowding in some households, which may have contributed to a number of the cases hospitalised in 2019/20.

OUTCOME MEASURES - Long Term[10]

Outcome: Children and adolescents have better oral health

Adolescents, in school Year 9 (13/14-year olds) up to and including 17 years of age, accessing DHB-funded oral health services. The decrease in DMFT (diseased, missing or filled teeth) at Year 8 however shows that the DHB has made an impact in promoting good oral health, by providing accessible publicly-funded adolescent oral health programmes. The programmes help reduce the prevalence and severity of oral disease in adolescents. This measure indicates the coverage of publicly-funded adolescent oral health services and provides a measure that can be used to demonstrate progress towards the population priority of "improving oral health" in the New Zealand Health Strategy.

Outcome measure 1: Increased number of Y9 – 17 year olds enrolled in DHB funded dental services



Data above is calendar year data and is reported in quarter 3 each year.

Outcome: Long-term conditions are detected early and managed well

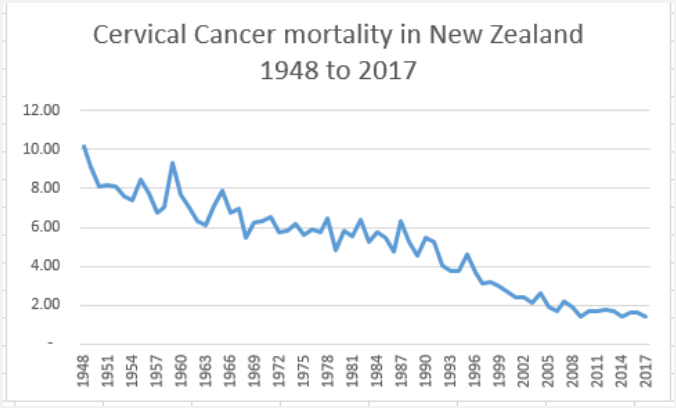
Cervical cancer is the fourth-most common cause of cancer and the fourth-most common cause of death from cancer in women worldwide. New Zealand has seen the number of women who die from cervical cancer dropping by 60 per cent since 1990 thanks to the screening programme. But still about 50 women die from it each year[11]. To continue this decline we need to increase our cervical screening rates to ensure cell changes are picked up at a treatable stage.

Cervical Cancer mortality in New Zealand 2011 to 2017

Rate per 100,000	2011	2012	2013	2014	2015	2016	2017
Total Population	1.7	1.8	1.7	1.4	1.6	1.6	1.4
Maori	5.4	3.7	4	3	3.6	3	3.2

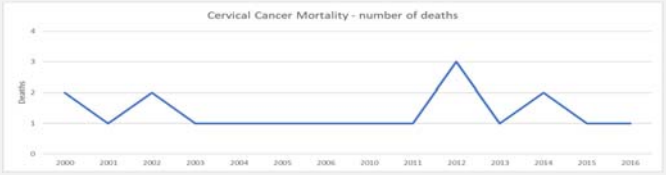
New Zealand cervical cancer mortality

Outcome measure 2: Reduced cervical cancer mortality rates



Source: Ministry of Health: Cancer Historical Summary 1948-2017[12].

Tairāwhiti cervical cancer mortality



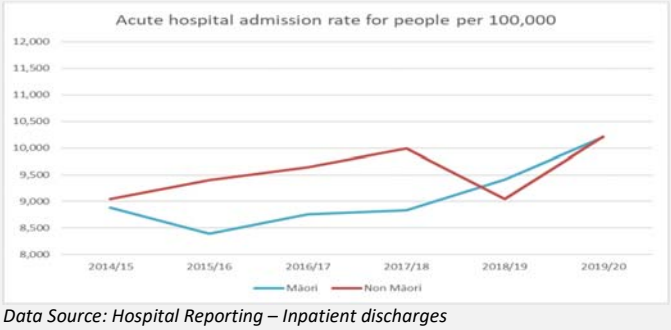
Source: Ministry of Health: Mortality data 2000 - 2016

Outcome: Fewer people are acutely admitted to hospital for avoidable conditions

International research has shown around 14% of acute admissions could have been prevented through better management of conditions in primary and community settings. To achieve our outcome of people staying well in their homes and communities, seamless flow through the health system is required. This will be achieved when the rate of admissions for acute medical conditions decreases.

Demand across the health sector in Tairāwhiti have seen continued growth across all areas but specifically in acute admission for medicine.

Outcome measure 3: Decreased Acute Medical Admissions Rate



Data Source: Hospital Reporting – Inpatient discharges

[10] Other entity information is unaudited

[11] https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/cervical-cancer

[12] As at 3 October 2019, https://www.health.govt.nz/publication/historical-mortality

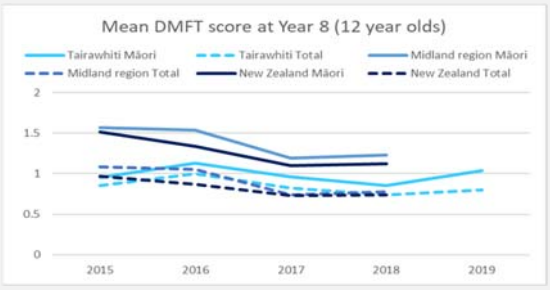
IMPACT MEASURES – Medium Term[13]

Outcome: Children and adolescents have better oral health

Improved oral health is a proxy measure of equity of access, and the effectiveness of mainstream services in targeting those most in need. DMFT is a count of decayed, missing or filled teeth in permanent dentition in a person's mouth. Around Year 8, children usually have lost their baby teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time. A continued decrease in the DMFT score of year 8 children will signal that we are succeeding.

	2016	2017	2018	2019
Tairāwhiti Māori	1.13	0.96	0.85	1.04
Tairāwhiti All	0.94	0.82	0.74	0.80
Midland Māori	1.54	1.19	1.23	national and regional data is unavailable at this time for 2019
Midland All	1.05	0.74	0.78	
NZ Māori	1.34	1.1	1.12	
NZ All	0.87	0.73	0.74	

Impact measure 1: Decreased Rate of Diseased Missing Filled Teeth in year 8 students (PP10)

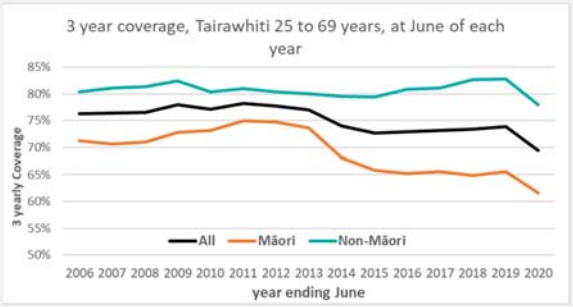


Data Source: Ministry of Health Performance Reporting

Outcome: Long-term conditions are detected early and managed well

Cervical cancer is one of the most preventable forms of cancer and screening every three years can reduce the risk of developing it by up to 90%. Identifying and treating cancers when they are small, is one of the most effective methods to reduce the impact of some cancers. Early detection will lead to either successful treatment, or delaying or reducing the need for hospital and specialist care.

Impact measure 2: Increased cervical screening rates



Data Source: Ministry of Health, NCSP New Zealand District Health Board Coverage Report 30 June 2020

[13]Other entry information is unaudited

Outcome: Fewer people are admitted to hospital for avoidable conditions

There are a number of hospital admissions for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care. A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases, and support enhanced delivery of the Government's priority of "better, sooner, more convenient" healthcare.

ASH rates for 12 months period to 30 June each year

0-4	Ethnic Group	12 months to June 2016	12 months to June 2017	12 months to June 2018	12 months to June 2019	12 months to June 2020
Tairawhiti	Other	5,957	6,667	5,042	5,143	4,819
Tairawhiti	Maori	6,720	8,240	7,390	7,782	7,177
Tairawhiti	Total	6,476	7,734	6,630	6,910	6,389
National	Total	6,842	6,409	6,904	6,804	5,397

45-64	Ethnic Group	12 months to June 2016	12 months to June 2017	12 months to June 2018	12 months to June 2019	12 months to June 2020
Tairawhiti	Other	2,572	3,126	2,548	3,204	3,335
Tairawhiti	Maori	4,569	5,415	5,633	5,831	6,746
Tairawhiti	Total	3,422	4,119	3,918	4,392	4,861
National	Total	3,795	3,898	3,900	3,907	3,689

Tairāwhiti ASH rates 2016-20

Impact measure 3: Decreased rate of ambulatory sensitive hospital admissions

Data Source: Ministry of Health Performance Reporting

OUTPUTS – Short Term Performance Measures

Outcome: Children and adolescents have better oral health

Indicator		Measure Type	2017/18 Result	2018/19 result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of Children (0-4) enrolled in DHB funded dental service (CW01)	Māori	Ω	104%	104%	**≥ 95%**	101%		🡻
	Non Māori	Ω	114%	114%		109%		🡻
	Total	Ω	107%	107%		104%		🡻
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (CW03)*	Māori	τ	13%	5%	**≤10%**	10.0%	N/A	🡹
	Non Māori	τ	12.5%	3%		5.4%		🡹
	Total Pop	τ	12.8%	4%		8.3%		🡹
Percentage of adolescent utilisation of DHB-funded dental services (CW04)	Total Pop	Ω	55%	52%	**≥85%**	50%	68%	🡻

* For the year ending 31 December

Outcome: Long term conditions are detected early and managed well

Indicator		Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of assessed high risk patients who have had an annual review (SS13 FA3)	Māori	Ω	54.1%	54.4%	≥90%	70.3%	N/A	↑
	Non Māori	Ω	54.7%	57.0%		59.5%		↑
	Total Pop	Ω	54.4%	55.7%		65.0%		↑
Percentage of eligible population will have had their cardiovascular risk assessed in the last 5 years (SS13, SLM)	Māori	Ω	89%	85.1%	≥90%	84.7%	77.5%	↓
	Non Māori	Ω	93%	89.4%		88.2%	78.6%	↓
	Total Pop	Ω	91%	87.3%		86.5%	78.4%	↓
Improve the proportion of patients with good or acceptable glycaemic control (HbA1c<64 mmol) (SS13)	Māori	Ω	46%	50%	≥90%	57%	N/A	↑
	Non Māori	Ω	54%	68%		58%		↓
	Total Pop	Ω	52%	57%		57%		→
Percentage of eligible women (25*-69) have a Cervical Cancer Screen every 3 years (SLM, PV02)	Māori	Ω /τ	71%	74%	≥80%	65%	61%	↓
	Non Māori	Ω /τ	79%	80%		80%	70%	→
	Total	Ω /τ	75%	77%		72%	76%	↓
Percentage of eligible women (50-69) who have had a Breast Screen in the last 2 years (PV01)	Māori	Ω /τ	69%	67%	≥70%	59.1%	60.3%	↓
	Non Māori	Ω /τ	72%	73%		73.3%	70%	→
	Total	Ω /τ	70%	70%		67.3%	66.8%	↓

Outcome: Fewer people are admitted to hospital for avoidable conditions

Indicator		Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of all Emergency Department presentations who triaged at level 4 & 5	Total Pop	Ω	67%	68%	≤50%	66%	N/A	↓
Percentage of eligible population who have their B4 School Checks completed (CW10)	High Needs	Ω /τ	95%	91.5%	≥90%	80.3%	90.7%	↓
	Total Pop	Ω /τ	93%	96.2%		86.6%	91.2%	↓

Indicator		Measure Type	2017/18 Result	2018/19	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Hospitalisation rates per 100,000 for acute rheumatic fever (CW13)	Total Pop	δ/τ	8.3	4.2	≤2.8	4.1	3.6	↓
Increased percentage of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools (CW12)[14]	Total Pop	δ/τ	44%	41.5%	≥95%	31.8%	N/A	↓
Improved waiting times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks	CT Scans	Ω/τ	92%	94%	≥95%	90.8%	81%	↓
	MRI Scans	Ω/τ	85%	81%	≥90%	81.2%	67%	↓

[14] Indicator is for non-planned care diagnostic only, with start time the date the Radiology Department receives the request and stop time the date the diagnostic was performed

Improved waiting times for diagnostic services – accepted referrals for non-urgent diagnostic colonoscopy	Within 42 days	τ	83.5%	63.8%	≥70%	80.1%	63.8%	⇳
Number of community pharmacy prescriptions	Total Pop	δ	475,732	476,117	450,000	475,760	94,633,262	⇳

Output class: INTENSIVE ASSESSMENT AND TREATMENT SERVICES PERFORMANCE

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action.

Goal 3 - People receive timely and appropriate specialist care

For those who do need a higher level of intervention, timely access to high quality complex care improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life. The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter wait times are also indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating with limited resources under increasing demand and workforce pressure. Reducing the waiting times diagnostic tests, cancer treatment and elective surgery requires organisational and clinical innovation.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that T Region has the capacity to provide for the complex needs of its population now and into the future.

2019/20 Intensive assessment and treatment services performance

It is encouraging to see the number of people within Tairāwhiti subject to compulsory treatment order under Section 29 of the 1992 Mental Health Act continues to fall and this is expected to continue with the roll out of changes to the Model of Care for Mental Health and Addiction services in 2020/21. In 2019/20, 100% of mental health whaiora discharged from community specialist mental health services have a wellness plan. Also notable is that the average length of stay for whaiora treated in an inpatient setting has fallen while the number of discharged receiving community care has increased.

The impact of COVID-19 pandemic response on oncology services was of concern and while rates for patients to received confirmation within 31 days decreased slightly the rates for those receiving treatment within 62 days increased and is now above the national target.

Another positive in 2019/20 was the increase in the number of outpatient appointments which were not missed for one reason or another. While overall and non-Māori rate was well under target and the Māori rate fell markedly the target rate was not achieved.

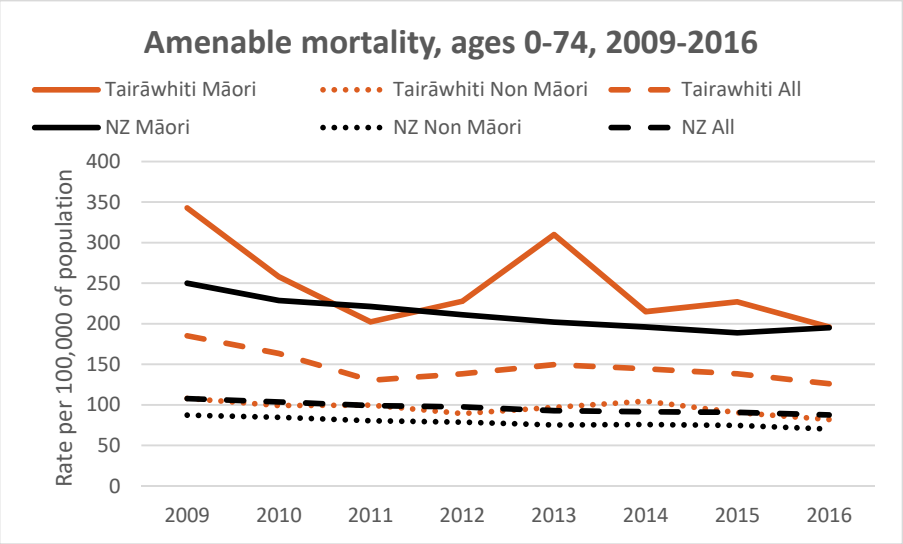
Planned care, previously called electives, was markedly impacted by staffing levels in the first half of 2019/20 and due to the covid-19 pandemic response this was not able to be made up in the later part of the year. With the reduction in the higher complexity surgery the length of stay for planned care surgery dropped markedly, this was also impacted by the additional effort placed into achieving colonoscopies in preparation for the rollout of the Bowel Screening programme in 2020/21.

OUTCOME MEASURES – Long Term[15]

Outcome: People receive prompt and appropriate acute care

About half the deaths under 75 years of age in New Zealand are classified as amenable. That is, they are 'untimely, unnecessary' deaths from causes manageable to health care. These causes range from some cancers to pregnancy complications to chronic disorders. Decreases in these rates are reflective of a high performing health system with seamless flow between Primary and Secondary Care Services. Although local rates follow the national decrease, they remain well above the national level.

Outcome measure 1: Decreased amenable mortality rate (SI9, SLM)

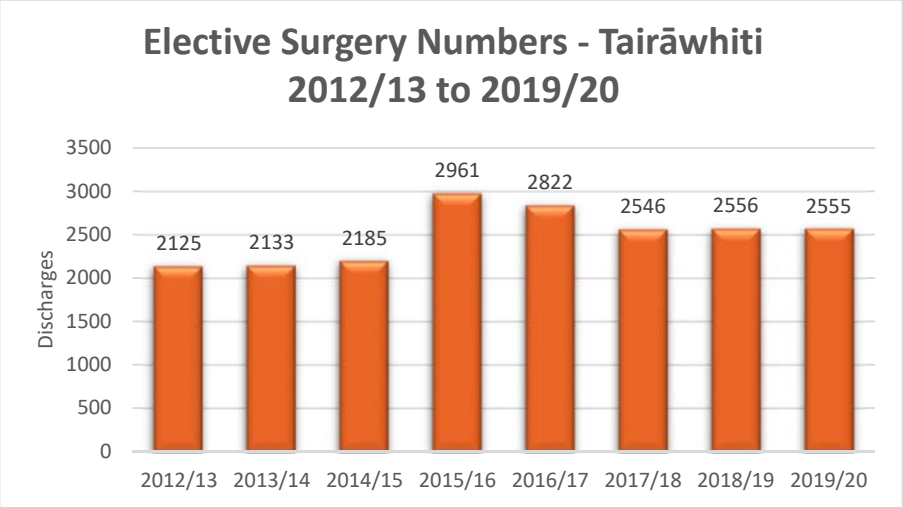


Data source: Amenable mortality SLM Data

Outcome: People have appropriate access to elective services

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services.

Outcome measure 2: Increased number of people receive elective surgery



Data Source: Ministry of Health Performance Reporting for Gisborne Hospital

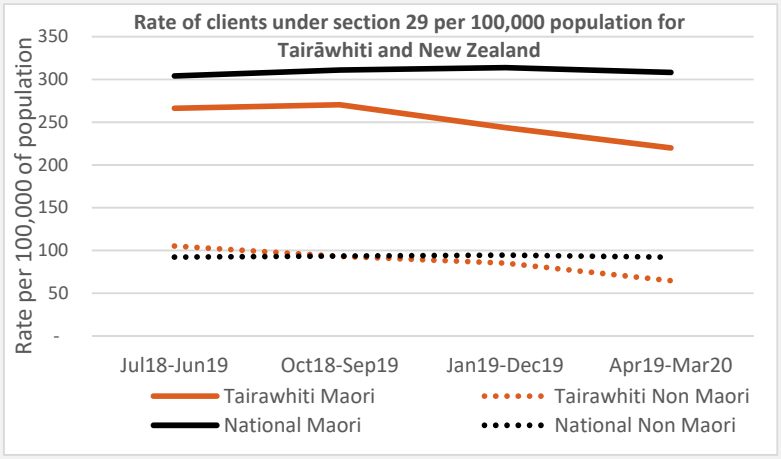
[15] Other entity information is unaudited

Outcome: Improved access to Mental Health services

It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. We work to reduce the high suicide rate and support our communities. By stimulating earlier access to mental health services and better access to community mental health services, we hope to see the number of people needing compulsory treatment decrease. For the future, we aim for a mental health care free of compulsory treatment and seclusion as these are a huge infringement of a person's freedom. This however, will need to be a long term goal as many factors contribute here.

Outcome measure 3: Reduce the number of Māori subject to compulsory treatment orders under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992

Data Source: Ministry of Health Performance Reporting PP36



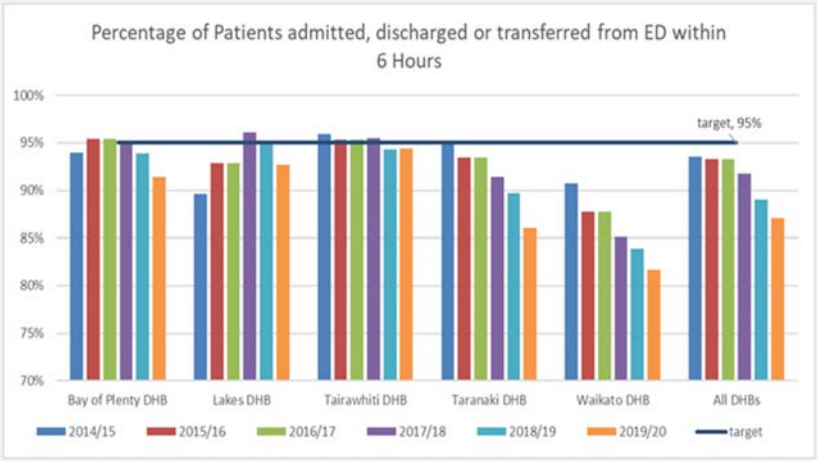
IMPACT MEASURES – Medium Term[16]

Outcome: People receive prompt and appropriate acute care

Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improve patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services. Solutions to reducing ED wait times need to address the underlying causes of delay and span not only our hospital services but the wider health system. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Impact measure 1: Patients admitted, discharged or transferred from ED within 6 hours

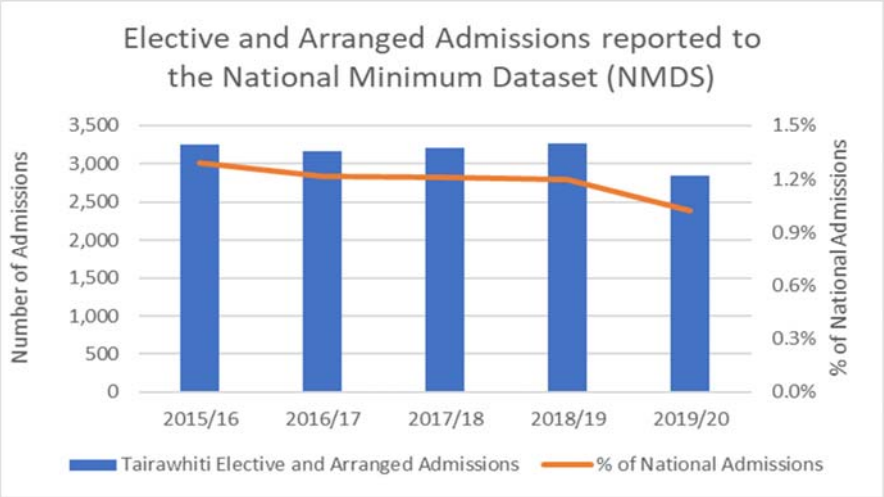


Data Source: MOH

[16] Other entity information is unaudited

Outcome: People have appropriate access to elective services

Improved performance against this measure is indicative of improved hospital productivity ensuring the most effective use of resources so wait times can be minimised and people in Tairāwhiti receive prompt and appropriate care when they need it.



Previous impact measure Standardised Discharge Rates per 10,000 for publicly funded discharges is no longer published by the Ministry of Health with the change to a planned care approach in 2019/2020.

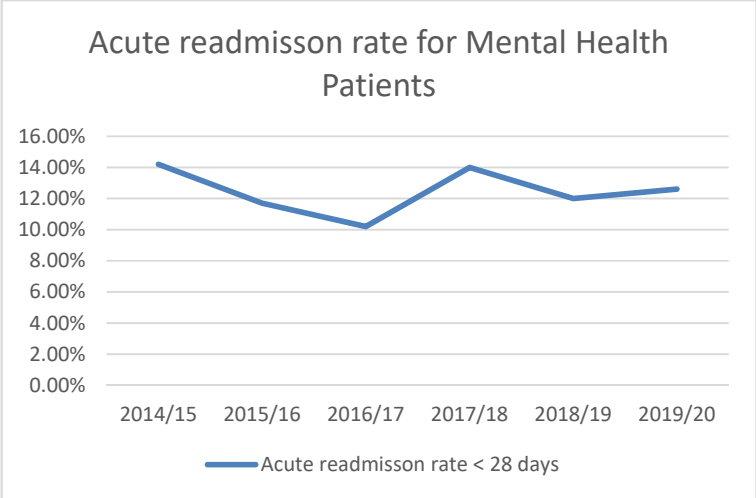
Outcome: Improved access to Mental Health services[17]

Access is the key to improving health status for people with a severe mental illness. Our goal is to build on our existing, and well established cooperation between primary / community and secondary services, by offering programmes to individuals and groups from a broad range of ages – children and youth, adults and older people.

If we improve access, and we provide services to people at the right time, and in the right place, we can expect to see a reduction in our 28 day readmission rate. This will, in turn, assist in reducing pressure on our hospital services.

Archive

Impact measure 3: Reduced 28 day acute readmission rate for Mental Health services



Data Source: Local Mental Health Dashboard

[17] Other entity information is unaudited

OUTPUTS – Short Term Performance Measures

Outcome: People receive prompt and appropriate acute care

Indicator		Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Standardised Acute Readmission rate (SS07)[18]	Total Pop	δ	11.1%	11.7%	≤10%	12.3%	12.1%	↑
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis (SS01)	Total Pop	τ	88%	92%	100%	87.9%	88%	↓
Faster Cancer Treatment – Proportion of patients with a high suspicion of cancer who receive their first cancer treatment within 62 days or less (SS01)	Total Pop	τ	88%	89%	≥90%	94.4%	85%	↑
Percentage of missed outpatient appointments[19]	Māori	δ	18%	20%	≤10%	14%	N/A	↓
	Non Māori		6%	6%		3.4%		↓
	Total		11%	12%		7%		↓

Outcome: People have appropriate access to elective services

Indicator		Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)[20] (SS07)		τ	19.9%	18.9%	0%	25.7%	N/A	↑
Number of surgical discharges under the elective initiative (SSO7)		δ	3,212	3,257	≥2,574	2,841	277,792	↓
Inpatient average length of stay (elective) (SS07)	Total Pop	δ/τ	1.41	1.45	≤1.45 days	0.56	N/A	↓

[18] 12 months data till the end of March
[19] Hospital reporting – Outpatients 2019/20
[20] Ministry of Health website – Elective Services Patient Flow Indicators (ESPIs) – Final – % waiting in June.

Outcome: Improved health status for people with severe mental illness and/or addictions

Indicator		Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (MH03)[21] Mental Health 0-19 yr olds		τ	71%	90%	≥80%	91.4%	65.1%	↑
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (Policy Priority 8) (MH03) Addictions 0-19 yr olds		τ	56%	87%	≥80%	71.4%	81.6%	↓
Improving the percentage of clients with wellness plan (MH02)	Total pop	δ	76%	73%	≥95%	100%	N/A	↑
Average length of acute inpatient stays for mental health (KPI 8)		Ω/δ/τ	20 days	20 days	14-21 days	13.9 days	N/A	↓
Rates of post-discharge community care (KPI 19)		Ω/δ/τ	42%	45%	≥90%	48%	N/A	↑

[21] Data for 12 months from April 18 till March 2019.

Output class: REHABILITATION AND SUPPORT SERVICES

Goal 4 – People maintain functional independence

The vision of the New Zealand Healthy Ageing Strategy is for older people to live well, age well and have a respectful end of life in age-friendly communities.

The constant evolution of medical sciences has allowed more people to live longer as more conditions can be cured and controlled. As people live longer, they often experience the effects of chronic conditions. Healthy ageing therefore, has not equally increased the quality of life in those extra years. For many people with chronic conditions, their quality of life is impacted significantly. We need to focus on adding more quality to those gained years. An important factor for people in their quality of life is to stay in control, to remain as independent as possible.

Clinicians, in cooperation with patients and their families, make decisions regarding treatment and care. Not all decisions should result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life.

As illness and disability effect an individual's functions, we need to support them in a way that maintains these functions as long as possible at the highest possible level. Support should be tailored to the individual's needs and evolve seamlessly with the changing functional abilities of that person. Regularly assessing these needs is a prerequisite for this. The interRAI assessment offers a very good picture of remaining functionality and support needs. The interRAI home care assessment is a prerequisite for home support, so all people receiving home support are assessed before they come into care. The care plan is an intrinsic part of this assessment. And this is how the indicator originally was interpreted. This does however not necessarily mean that people who remain in care longer are reassessed after that first assessment. For long-term home support clients, an assessment is required every three years, or if there is a significant change in their condition. Therefore, we changed the indicator to 'Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 36 months'. Analysis of the interRAI data shows us that indeed all home support clients have at least one inter RAI assessment in the last three years. We added the 12 months indicator as well, as this shows us how many people receiving home support, were assessed in the last year. The 33% result here shows that indeed one out of three home support clients had an assessment in the last 12 months, so we are on track to maintain the 100% for the 36 months indicator. Analysis of the assessments shows that people were reassessed according to changes in their circumstances: after a hospital discharge and if their condition had deteriorated or routinely after they had been receiving home support for almost three years.

In the future, we hope to build a more flexible home support model, based on measured changes in client's needs. However, the time investment required to do an interRAI home care assessment does not allow us to increase the frequency of this assessment. Therefore, we might look at shorter interRAI assessments that allow measuring a client's support and health needs more frequently.

Even if very little functional independence is left, people should be able to stay in control of their life. Advanced care plans are a very valuable instrument to make sure that a person can remain in charge even if he/she can't express his/her wishes anymore.

2019/20 Rehabilitation and Support Services performance

2019/20 was a significant year for this area with the implementation of the Home Care Support Services model of care, this differs for the previous Home Based Support Services model of care by looking to restore as much independence as possible of those older people who received home support. This it achieves by increasing the clinical input into assessing the cares an older person receives. In the longer term this will slow the progression of those conditions which see older people receiving more intensive supports as well as reduce the need for aged related residential care.

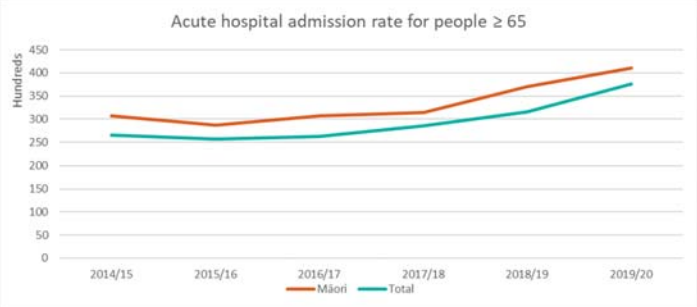
While it is too early to assess the impact on this model of care, it is of note that the number of people in aged care fell in 2019/20. The COVID-19 pandemic response may have some impact within 2019/20 but this trend was seen throughout 2019/20.

OUTCOME MEASURES – Long Term[22]

Outcome: People stay well in their home and community

Elderly people take up a large part of acute hospital admissions. Hospital admissions are, apart from the financial impact on the Health Care budget, often very disturbing and even dangerous for these vulnerable elderly. Elderly admitted to hospital are at risk of developing delirium, hospital acquired infections, and loss in their capability of daily life activities.
Approximately a quarter of all medical and surgical discharges in older adults were ambulatory sensitive admissions[23]. Some of these admissions could possibly have been avoided by better management of the multipathology of this geriatric population and improved home support. This requires coordinated care between all community partners (GP, Pharmacist, Community nurse, Home Support,..) in combination with secondary care, allied health services, social services and other support agencies.

Outcome measure 1: Decreased rate of acute admissions for people > 65 years



Acute hospital admissions for people ≥ 65 per 100,000 population 65+
Source: Hospital Reporting

Possible interventions[24]:

- Social history patient
- Preventive measures: influenza and pneumococcal vaccination
- Support independence: Fall prevention, Assess nutritional status, vit D supplements,
- Regular medicine review
- Coordination of care

Outcome: People with end stage conditions are supported

When people reach the final months and weeks of their life, they have the right to be cared for in a proactive, holistic way.

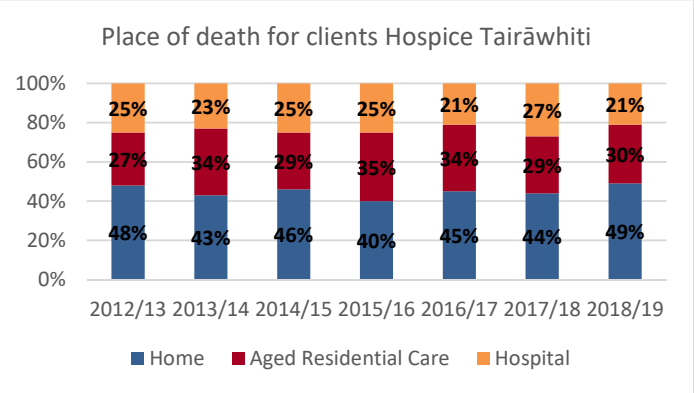
When asked about their wishes regarding end of life, most people say they would like to die at home. Unfortunately too many people still die in hospital.

Hospice Tairāwhiti, provides palliative care and support to make it possible for peope to die in their preferred setting. We see the number of people they care for increasing.

In our aim to provide a safe and serene care setting, it is important to avoid unnecessary hospital admissions, transfers and diagnostics or unhelpful treatment. Focus should be on supporting the quality of the life that is left.

Open and timely discussion about their wishes regarding their end of life (palliative and terminal phase) is of high importance for tailored end of life care later on. This starts with the open recognition of the end stage of their condition by clinicians.

Outcome measure 2: End of life care is provided in a place of residence



Source: Hospice Tairāwhiti Annual Report

[22] Other entity information is unaudited
[23] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/older-adult-ambulatory-sensitive-hospitalisations/
[24] Prevention is better than cure: five tips for keeping older people healthy and out of hospital during winter. BPac Best Practice Journal, 2015. https://bpac.org.nz/BPJ/2015/June/tips.aspx

IMPACT MEASURES – Medium Term[25]

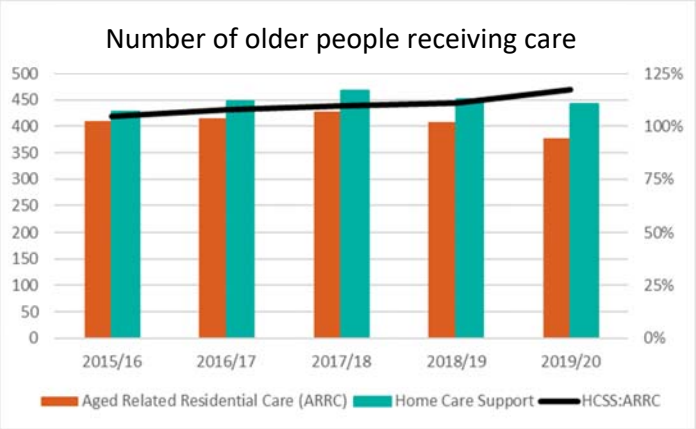
Outcome: People stay well in their home and community

Most elderly people hope to live in their own home or with whānau in their community for as long as possible. Most of them dread a possible move into residential care. When people's ability to perform every day life activities decreases, they often rely on whānau, neighbours and friends for support. If this is not sufficient or the care for the person becomes too hard for these people, a move into residential care often seems to be the only solution.

Residential care is, apart from not being the home of choice for many elderly, also costly for both the client and his whānau as for the public health system.

By better supporting the vulnerable elderly and their whānau, residential care admission often can be delayed or even avoided. Yearly approximately 6% of our population 65 and over, receive some funding for Aged Related Residential Care (ARRC), and 9% for Home Based Support Services. This proportion has been the same for the last 5 years.

Impact measure 1: Increased ratio of long-term home support clients over people in residential care



Source – Client Claims Processing System (CCPS)

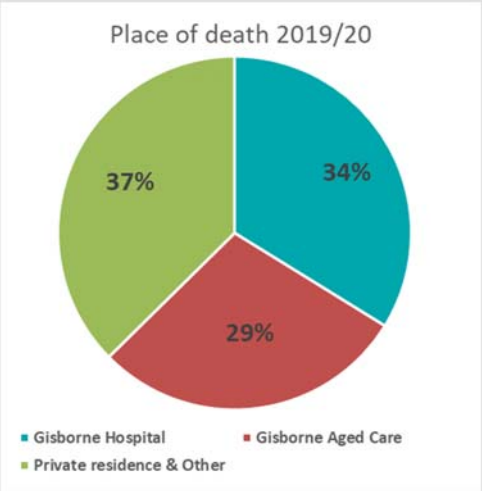
Outcome: People with end stage conditions are supported

International research has shown that, when asked about their own death, most people would prefer to die at home. A lot of people however, are still rushed to hospital in their final days. By stating what matters to them about their end-of life care in an advanced care plan, people can trust that their wishes will be the guideline for their end of life stage, even if they are no longer able to express those wishes.

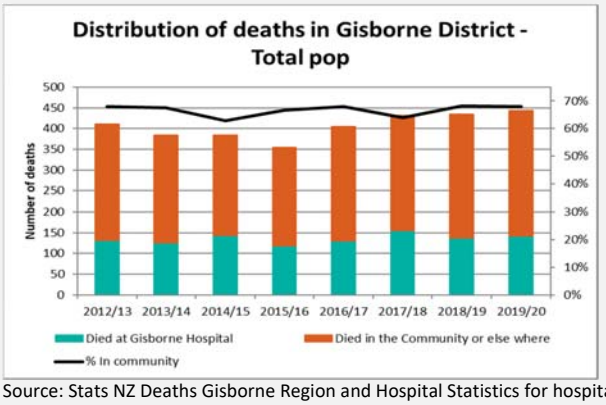
Providing everyone with the right level of care in their place of residence, will allow more people to also spend their final days there.

Although place of death is recorded on the death certifcate, this is not coded and therefore not reported in the mortality statistics.

Impact measure 2: People can die at home



Source: local data



Source: Stats NZ Deaths Gisborne Region and Hospital Statistics for hospital deaths

[25] Other entity information is unaudited

OUTPUTS – Short Term Performance Measures

Outcome: People stay well in their home and community

Indicator	Measure Type	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan in the last 36 months	δ	100%	93%	100%	95%	N/A	➚
Percentage of older people receiving home support who have had a comprehensive clinical assessment and an individual care plan in the last 12 months	Ω	33%	49%[26]	33%	34%	N/A	➘

*Every client receiving home support has a clinical assessment. As required by the Ministry, reassessment of clients receiving long-term home support is only done every three years unless major changes to their condition. Care Plans are part of the clinical assessment. As people are only reassessed within a three year period if their condition has changed significantly, the number of home support clients receiving an assessment compared to the total number of clients can be a quality indicator for the provided care.

Outcome: People with end stage conditions are supported

Indicator	Measure Type	2017/18 Result	2018/19Result	2019/20 Target	2019/20 Result	Latest NZ Result	Trend
Number of hospital admissions under Health Speciality Code M80 (Palliative Care)	Ω	5	8	Increase	5	N/A	➘
Number of falls in Aged Residential Care Facility resulting in admission[27]	δ	New Measure		N/A	N/A	N/A	-
Number of pressure injuries[28]	δ	New Measure		N/A	N/A	N/A	-
Number of aged residential care facilities utilising Advanced Directives	δ	6[29]	6	Increase	6	N/A	➲

[26] Clients receiving care as per 30/06/2019 who had had an interRAI assessment after 30/06/2018.
[27] Proposed Database has been delayed in 2019/20 no record of falls in ARRC
[28] Impacted by COVID-19 and data is incomplete for the full year.
[29] All the local rest homes use advanced directives in some form.

Summary of Revenue and Expenses by Output Class

Statement of Intent

The Crown Entities Act 2004 requires DHBs to report revenue and expenses for each Output Class.
There are four output classes for 2019/20

- Prevention
- Early detection and management
- Intensive assessment and treatment
- Rehabilitation and support.

Hauora Tairāwhiti has allocated the revenues and expenses to each output class for the periods covered by this report and the results are as per the table below:

Output Class Funding Allocation

	Actual 2020 $000's	Budget 2020 $000's	Actual 2019 $000's
Income			
Prevention	($10,158)	($5,268)	($9,456)
Early detection and management	($47,177)	($55,198)	($47,134)
Intensive assessment and treatment	($124,431)	($120,567)	($116,113)
Rehabilitation and support	($25,706)	($23,754)	($26,133)
Total Income	**($207,472)**	**($204,787)**	**($198,836)**
Expenditure			
Prevention	$6,790	$5,268	$6,515
Early detection and management	$47,571	$55,198	$47,277
Intensive assessment and treatment	$140,073	$132,566	$141,463
Rehabilitation and support	$27,462	$23,754	$26,610
Total Expenditure	**$221,896**	**$216,786**	**$221,865**
Surplus/(Deficit)	**($14,424)**	**($11,999)**	**($23,030)**

Statutory Information

New Zealand Public Health and Disability Act 2000

Report on the extent to which Hauora Tairāwhiti has met its objectives under section 22 [s.42 (3) (b)];

This information can be found in the Statement of Service Performance commencing on page 16. Each objective included in the Statement of Service Performance is referenced back to objectives (a) to (k) from section 22 of the New Zealand Public Health and Disability Act 2000.

(a) To improve, promote, and protect the health of people and communities.

(b) To promote the integration of health services, especially primary and secondary health services.

(c) To promote effective care or support for those in need of personal health services or disability support services.

(d) To promote the inclusion and participation in society and independence of people with disabilities.

(e) To reduce health disparities by improving health outcomes for Māori and other population groups.

(f) To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

(g) To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services.

(h) To foster community participation in health improvement and in planning for the provision of services and for significant changes to the provision of services.

(i) To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.

(j) To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.

(k) To be a good employer.

Statement of how Hauora Tairāwhiti has given effect and intends to give effect to its functions specified in section 23(1) (a) to (e) [s.42 (3) (i)];

(a) To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement:

- All Crown Funding Agreement (CFA) actions for the period completed as required.
- Compliance with the Service Coverage Schedule for both Hauora Tairāwhiti provider and other community providers via service agreements (excluding those exceptions to meeting the schedule, as outlined in Hauora Tairāwhiti's Annual Plan).
- Overall outputs for the provider arm met – with variation between service lines.

(b) To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:

- Hauora Tairāwhiti has developed a series of clinical alliances with other DHBs and providers both locally and across the country in order to achieve its aims.
- Hauora Tairāwhiti is a member of DHB Shared Services, the joint agency for all DHBs. Hauora Tairāwhiti contributes to, and gains benefit from collaborative action to advance the aims of Hauora Tairāwhiti and the health sector in general.

(c) To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):

- Hauora Tairāwhiti has a positive relationship with the local media, particularly the newspaper.
- All matters of importance are communicated to the Tairāwhiti population.

- Regular contact with other providers is maintained.
- Regular reporting to the MoH.
- Regular reporting to Board and Advisory Committees via public accountability system.

(d) To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:

- The Māori Caucus Te Waiora o Nukutaimemeha sits alongside the Hauora Tairāwhiti Board at a governance level, therefore ensuring active participation and contribution by Māori.
- The Board of Hauora Tairāwhiti meets with Boards of Māori providers on an annual basis
- The Board of Hauora Tairāwhiti meets once a year with representatives of the Runanga with which it has signed Memorandum of Understanding. The two Runanga are Te Runanganui o Ngāti Porou and Te Runanga o Turanganui a Kiwa.
- Involvement of Koroua / Kuia in services.

(e) To continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:

- Funding of Māori providers.
- Joint application of the Māori provider development funding held by the MoH.

Ministerial Directions

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property and the former two apply to DHBs.
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.
- In addition DHBs were advised in March 2020 by the Minister of Health that he had issued COVID-19 response direction.

Statement of Responsibility

The Board accepts responsibility for the preparation of the Financial Statements and Statement of Service Performance and for the judgements used in them.

The Board accepts responsibility for any end-of-year performance information provided by Hauora Tairāwhiti under section 19A of the Public Finance Act 1989.

The Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the opinion of the Board, the Financial Statements and Statement of Service Performance for the year ended 30 June 2020 fairly reflect the financial position and operations of Hauora Tairāwhiti.

Signed on behalf of the Board of Hauora Tairāwhiti:

Kim Ngarimu
Hauora Tairāwhiti Board Chair

Date: 18 December 2020

Heather Robertson
Hauora Tairāwhiti Board Member

Date: 18 December 2020

Independent Auditor's Report

To the readers of Hauora Tairawhiti District Health Board Group's financial statements and performance information for the year ended 30 June 2020

The Auditor-General is the auditor of Hauora Tairawhiti District Health Board and Group (the Group). The Auditor-General has appointed me, Kelly Rushton, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Group on his behalf.

We have audited:

- the financial statements of the Group on pages 47 to 71, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 18 to 39.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Group on pages 47 to 71:

- present fairly, in all material respects:
  - its financial position as at 30 June 2020; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Unmodified opinion on the performance information

In our opinion, the performance information of the Group on pages 18 to 39:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2020, including:
  - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 18 December 2020. This is the date at which our qualified opinion is expressed.

The basis for qualified opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion on the financial statements and unmodified opinion on the performance information

As outlined in note 18 on page 65, the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes a provision of $9.316 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the Group's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $8.619 million provision as at 30 June 2019. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide the basis for our qualified opinion on the financial statements and the basis for our unmodified opinion on the performance information.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements.

The Group is reliant on financial support from the Crown

Note 1 on page 52 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances, which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Group will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Group over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Note 31 on page 70 outlines the impact of Covid-19 on the group.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Group or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the group audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 17, 40 to 42, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the Group.

Kelly Rushton
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Statement of Comprehensive Revenue & Expense

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Revenue				
Patient care revenue	2 i	205,241	204,079	197,804
Interest revenue		70	105	159
Other revenue	2 ii	2,161	603	773
Total revenue		207,472	204,787	198,736
Expenses				
Personnel Cost	3	84,756	82,908	87,521
Depreciation and amortisation expenses				
Property, plant and equipment	12	3,027	3,188	2,990
Intangible assets	13	269	303	289
Outsourced services		9,333	6,273	9,392
Clinical Supplies		17,649	17,628	17,066
Infrastructure and non-clinical expenses		9,119	9,554	9,704
Other district health boards		24,055	24,074	23,583
Non-health-board provider expenses		71,373	69,945	68,075
Capital charge	4	1,898	2,439	2,679
Interest expense		69	117	86
Other expenses	5	1,106	707	1,042
Total expenses		222,654	217,136	222,427
Share of associate surplus / (deficit)	11	758	350	661
Surplus / (deficit)		(14,424)	(11,999)	(23,030)
Other comprehensive revenue and expense				
Revaluation of land and buildings		0	0	0
Total other comprehensive revenue and expense		0	0	0
Total comprehensive revenue and expense		(14,424)	(11,999)	(23,030)

Explanations of major variances against budget are provided in Note 29.
The accompanying notes form part of these financial statements.

Statement of Financial Position

Statement of Financial Position
As at 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Assets				
Current Assets				
Cash & cash equivalents	6	13,159	148	174
Receivables	7	4,292	5,660	4,700
Prepayments		1,455	1,026	1,467
Inventories	9	1,983	1,862	1,952
Total current assets		20,889	8,696	8,293
Non-current assets				
Investments in subsidiary and associates	11	1,198	923	1,010
Property, plant and equipment	12	61,162	63,336	61,621
Intangible assets	13	2,757	1,320	2,281
Total non-current assets		65,117	65,579	64,912
Total assets		86,006	74,275	73,205
Liabilities				
Current Liabilities				
NZ Health Partnership Ltd	6	0	3,969	580
Payables and deferred revenue	14	18,782	10,746	12,951
Borrowings	16	159	138	148
Employee entitlements	17	14,554	10,587	12,701
Total current liabilities		33,495	25,440	26,380
Non-current Liabilities				
Borrowings	16	403	711	562
Employee entitlements	17	10,276	990	9,625
Total non-current liabilities		10,679	1,701	10,187
Total liabilities		44,174	27,141	36,567
Net Assets		41,832	47,134	36,638
Equity	19			
Crown equity		80,099	72,127	60,481
Accumulated surpluses / (deficits)		(77,299)	(63,997)	(62,875)
Property revaluation reserves		39,004	39,004	39,004
Trust funds and bequests		28	0	28
Total equity		41,832	47,134	36,638

Explanations of major variances against budget are provided in Note 29.
The accompanying notes form part of these financial statements.

Statement of Changes in Equity

Statement of Changes in equity
For the year ended 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Balance at 1 July		36,638	47,516	49,050
Total comprehensive revenue and expense		(14,424)	(11,999)	(23,030)
Owner transactions	19			
Capital contribution		20,000	11,999	11,000
Crown loans converted to equity		0	0	0
Repayment of capital		(382)	(382)	(382)
Bequest Trusts interest		0	0	0
Balance at 30 June		41,832	47,134	36,638

Explanations of major variances against budget are provided in Note 29.
The accompanying notes form part of these financial statements.

Statement of Cash Flow

Statement of Cash Flows
For the year ended 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Cash flows from operating activities				
Receipts from patient care				
Ministry of Health		196,925	195,432	189,803
Other District Health Boards		2,449	2,360	2,374
Other		7,221	6,211	6,946
Receipts from other revenue		2,161	678	773
GST (net)		334	0	27
Payments to suppliers		(104,044)	(103,750)	(103,985)
Payments to Other District Health Boards		(24,055)	(24,074)	(23,583)
Payments to employees		(82,252)	(82,908)	(76,772)
Capital charge		(1,898)	(2,439)	(2,679)
Net Cash flow from operating activities		(3,159)	(8,490)	(7,096)
Cash flow from investing activities				
Distributions from subsidiary company		570	0	574
Interest receipts		69	105	159
Receipts from sale of property, plant, and equipment		0	0	0
Purchase of property, plant and equipment		(2,568)	(2,858)	(3,129)
Purchase of intangible assets		(745)	(91)	199
Net cash Flow from investing activities		(2,674)	(2,844)	(2,197)
Cash flow from financing activities				
Capital contributions from the crown		20,000	12,000	11,000
Interest paid		(71)	(117)	(88)
Repayment of capital to the Crown		(382)	(382)	(382)
Repayment of finance leases		(149)	0	(153)
Net cash flow from financing activities		19,398	11,501	10,387
Net (decrease) / increase in cash and cash equivalents		13,565	167	1,094
Cash and cash equivalents at the start of the year		(406)	(3,988)	(1,500)
Cash and cash equivalents at the end of the year	6	13,159	(3,821)	(406)

Explanations of major variances against budget are provided in Note 29.
The accompanying notes form part of these financial statements.

Reconciliation of Net Surplus/Deficit to net cash flow from operating activities

For the year ended 30 June 2020	Actual 2020 $000	Actual 2019 $000
Net surplus / (deficit)	(14,424)	(23,030)
Add / (less) non-cash items		
Share of associates surplus	(758)	(661)
Increase in non-current employee entitlements	651	8,635
Depreciation and amortisation expense	3,296	3,279
Other non-cash items	0	0
Net change on financial instruments and term liabilities	58	58
Total non-cash items	3,247	2,676
Add / (less) items classified as investing or financing activities		
Interest reclassified in the current year	0	0
Total items classified as investing or finance activities	0	0
Add / (less) movements in statement of financial position items		
(Increase) / decrease in receivables	408	959
(Increase) / decrease in prepayments	12	(441)
(Increase) / decrease in inventories	(31)	(90)
Increase / (decrease) in payables	5,776	2,081
Increase / (decrease) in employee entitlements	1,853	655
Net movements in working capital items	8,018	4,623
Net cash (outflow) / inflow from operating activities	(3,159)	(7,096)

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Note 1: Statement of Accounting Policies

Reporting / Economic Entity
Hauora Tairāwhiti is a Health Board established by the New Zealand Public Health and Disability Act 2000. Hauora Tairāwhiti is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The group consists of Hauora Tairāwhiti, its subsidiary company Tairāwhiti Laundry Services Limited (TLSL), which holds the associated partnership share in Gisborne Laundry Services (GLS), *and its associated companies HealthShare Limited and TLab Limited (TLab).*

The group activities involve delivering health and disability services and mental health services in a variety of ways to the community. Hauora Tairāwhiti does not operate to make a financial return.

Hauora Tairāwhiti is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP).

Basis of preparation
The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of Going Concern
The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2019/20 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Operating and Cash flow forecasts
The key considerations are set out below:

- Operating and Cash flow forecasts:
  The Board has considered forecast information relating to operating viability and cash flow requirements. Without deficit support, the Board is not satisfied there will be sufficient cash flows generated from operating activities to meet its cash flow requirements of the DHB as set out in it the 2020/21 Statement of Performance Expectations and based on current trading conditions and legislative requirements.

- Letter of comfort
  The Board has received a letter of comfort, dated 29 September 2020, from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

  As at the date of publishing these financial statements, no agreement has been reached with the Ministry of Health as to the actual value and timing of any deficit support to be provided to the DHB in accordance with the letter of comfort.

  Capital injection of $20m was received during the 2019/20 financial year.

Statement of Compliance
The financial statements of Hauora Tairāwhiti have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with GAAP. The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Presentation currency and Rounding
The financial statements are presented in NZ dollars rounding to the nearest thousand ($000) except for Note 23 which is in whole dollars.

Standard early adopted
In line with the Financial Statements of the Government, Hauora Tairāwhiti has elected to early adopt *PBE IFRS 9* Financial Instruments. *PBE IFRS 9* replaces *PBE IPSAS 29* Financial Instruments: Recognition and measurement. Information about the adoption of *PBE IFRS 9* is provided in Note 25.

Standards issued and not yet effective and not early adopted
Standards and amendments, issued but not yet effective, that have not been early adopted are:

Amendment to PBE IPSAS 2 Statement of Cash Flows
An amendment to *PBE IPSAS 2 statement of Cash Flows* requires entities to provide disclosures that enable users of the financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Hauora Tairāwhiti does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments
The XRB issued *PBE IPSAS 41 Financial Instruments* in March 2019. This standard supersedes *PBE IFRS 9* Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Hauora Tairāwhiti has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to *PBE IFRS 9*.

PBE FRS 48 Service Performance Reporting
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Hauora Tairāwhiti has not yet determined how application of PBE FRS 48 will effect is statement of performance.

Changes in accounting Policies
There have been no changes in accounting policies.

Significant Accounting Policies
Significant accounting policies are included in the notes to which they relate, other policies are listed below.

Goods and services tax
All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense. The net GST recoverable or payable is included as part of receivables or payables in the Statement of Financial Position. All GST paid or received is classified as an operating cash flow in the Statement of cash flows.

Taxation
Hauora Tairāwhiti is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 2007.

Budget figures
The budget figures are those approved by the Board and published in its Statement of Performance Expectations and have been prepared in accordance with GAAP and are consistent with the accounting policies adopted by the Board.

Cost of service statements
The cost of service statements, as reported in the statement of objectives and service performance, reports the net cost of services for the outputs of Hauora Tairāwhiti and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation
Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Indirect costs are charged to outputs based upon cost drivers and related activity or usage information.
There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions
In preparing these financial statements, Hauora Tairāwhiti has made estimates and assumptions concerning the future. These estimates and assumptions might differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:

- Retirement and Long Service Leave – refer to Note 17
- Holidays Act compliance – refer to Note 17

Note 2: Revenue

Accounting Policy

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population based revenue

Hauora Tairāwhiti receives annual funding from the ministry, which is based on the population of our district. This funding is restricted in its use for the purpose of Hauora Tairāwhiti meeting its objectives as specified in the statement of intent and is recognise based upon the funding entitlement for the year.

Ministry of Health contract revenue

Revenue recognition depends upon the contract terms. Those contracts where the amount of revenue is linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the services are provided, other contracts are treated as non-exchange and the total receivable is recognised as revenue immediately, unless there are substantive conditions in the contract.

Revenue from other District Health Boards

Hauora Tairāwhiti receives inflow revenue when a patient who is domiciled outside our district is treated within our district. This revenue is recognised when the eligible services are provided.

ACC contract revenue

Revenue is recognised when eligible services are provided and contract conditions have been fulfilled.

Interest Revenue

Revenue recognised using the effective interest method.

Rental Revenue

Revenue recognised over a straight-line basis over the lease term.

Other Service Revenue

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion, based on the actual service provided as percentage of the total service to be provided.

Donations, grants and bequests

Revenue recognised immediately unless there are conditions to be fulfilled, in which case a liability is recorded and then released as the conditions are fulfilled.

Where a physical assets is gifted to or acquired by Hauora Tairāwhiti for nil consideration or a subsidised cost, the asset is recognised at fair value and the difference between the fair value and consideration provided is recognised as revenue.

Donated services

Certain operations of Hauora Tairāwhiti are partially reliant on services provided by volunteers, these services are not recognised as revenue or expenditure.

i Patient Care Revenue	Actual 2020 $000	Actual 2019 $000
MoH population-based Funding	171,761	165,255
MoH other contracts	24,447	24,299
Inter-district Flows (other DHBs)	2,449	2,374
Other patient care related revenue	6,584	5,876
Total Patient care revenue	205,241	197,804

Performance against the MoH population based funding is reported in the Statement of service performance section of the Annual Report.

As required by the Public Finance Act 1989, Hauora Tairāwhiti received $175,757k of revenue from the Crown as part of the Vote Health appropriations. This amount equals the actual expenses incurred by the Government in relation to the appropriation.

Hauora Tairāwhiti has considered the Direction 2011 "Health and Disability Services Eligibility" issued by the Minister of Health pursuant to section 32 of the NZ Public Health and Disability Act 2000, when establishing patient's eligibility for funded services from the DHB.

ii Other Revenue	Actual 2020 $000	Actual 2019 $000
Donated equipment	0	0
Cash donation received	68	59
Rental revenue	259	229
Other revenue	1,834	485
	2,161	773

Note 3: Personnel costs and employee remuneration

Accounting Policy
Salaries and wages
Salaries and wages are recognised as an expense as employees provide services.

Employee entitlements
- Annual, parental and conference leave are based on an actual entitlement basis at current rates of pay.
- Long service and retirement provisions are calculated on an actuarial basis.
- Sick leave is recognised to the extent that compensated absences in the coming year are expected to be greater than the leave entitlements earned in the coming year.
- Other leave provisions are based upon the amount expected to be used in the coming year
- During the year provision has been made in relation to compliance with the Holidays Act 2003 $847k (2019; $8,469k) all of which is a long term liability at this stage. This provision has been calculated on a sample of 40 employees over a period of nine years and adjusted for the current Headcount. The figures in the table below also includes a short term provision of $150k to complete the work required to meet this liability.
- Provision was made in 2019 in relation to payments for Meals on Duty, this has been calculated at $630k and covers a period of six years

Superannuation schemes
Defined contribution schemes
Employer contributions to Kiwisaver, government superannuation and the State sector retirement saving scheme are accounted for as defined contribution schemes and are recognised as an expense as incurred.

Defined benefit schemes
Hauora Tairāwhiti makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme. Insufficent information is available to use defined benefit accounting, as it not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Breakdown of personnel costs	Actual 2020 $000	Actual 2019 $000
Salaries and wages	80,537	75,126
Defined contribution plan employer contributions	1,715	1,646
Increase / (decrease) in liability for employee entitlements	1,507	1,500
Holidays Act Compliance/ Meals on Duty Liability	997	9,249
	84,756	87,521

Employee remuneration

The number of employees or former employees during 19/20 who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

From	To	Staff No. 2020	Staff No. 2019
100,000	109,999	26	38
110,000	119,999	21	16
120,000	129,999	9	8
130,000	139,999	5	3
140,000	149,999	1	5
150,000	159,999	5	2
160,000	169,999	4	7
170,000	179,999	1	1
180,000	189,999		2
190,000	199,999	1	2
200,000	209,999		1
210,000	219,999	2	2
220,000	229,999	2	
230,000	239,999	1	2
240,000	249,999		2
250,000	259,999	2	2
260,000	269,999	4	2
270,000	279,999	1	2
280,000	289,999	2	
290,000	299,999	2	3
300,000	309,999		3
310,000	319,999	6	2
320,000	329,999	7	2
330,000	339,999	4	3
340,000	349,999	1	5
350,000	359,999	3	2
360,000	369,999	3	5
370,000	379,999	2	1
380,000	389,999	3	4
390,000	399,999	1	1
400,000	409,999	2	3
410,000	419,000	1	1
420,000	429,999	2	2
430,000	439,999	3	
440,000	449,999		
450,000	459,999		
460,000	469,999	1	
470,000	479,999	1	
480,000	489,999		1
490,000	499,999	1	1
560,000	569,999		1
		130	137

During the year ended 30 June 2020, 3 (2019:6) employees received compensation and other benefits in relation to cessation totalling $75K (2019: $40K).

Note 4: Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates. Haoroa Tairāwhiti pays capital charge every six months to the Crown based upon the closing equity balance for the previous six months. The capital charge rate of the year was 6% (last year 6%).

Note 5: Other expenses

	Note	Actual 2020 $000	Actual 2019 $000
Fees to auditor			
- Audit NZ for audit of the financial statements		129	114
- Audit of Subsidiary Accounts		3	3
- Internal audit fees		154	129
Bad debts written off		9	41
Operating lease expense		471	381
Board member fees	23	254	298
Board election expenses		65	9
Loss on disposal of property, plant and equipment		0	0
Other Expenses		21	66
		1,106	1042

Note: Fees above for Board members are just the fees for meetings. Figures included in Note 23 include expenses relating to meeting as well as the fees for attending meetings.

Accounting Policy

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases and are recognised as expense in the periods in which they are incurred.

Note 6: Cash and cash equivalents

Accounting Policy

Cash and cash equivalents comprise cash balances, call deposits with maturities less than three months.

	Actual 2020 $000	Actual 2019 $000
Cash at bank and on hand	12,952	10
Deposits with maturities less than 3 months	207	164
	13,159	174
NZ Health Partnership Ltd	0	(580)
Total cash and cash equivalents	13,159	(406)

Hauora Tairāwhiti is a party to a DHB Treasury Services Agreement between NZ Health Partnership Ltd (NZHP) and all the DHBs. This agreement allows NZHP to sweep all the DHB banks accounts and invest surplus funds on DHB behalf. The agreement also allows DHBs to borrow from NZHP, which will incur interest at an on-call interest rate received by NZHP plus an administration margin. The maximum borrowing facility available to any DHB is the value of one twelfth of the Provider arm funding plus GST. As at 30 June this year the amount was $9,851 million (2019: $9,402 million).

Included in cash and cash equivalents are unspent funds with restrictions on expenditure. Further information about trust funds is provided in note 19.

Note 7: Receivables

Accounting Policy

Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that Hauora Tairāwhiti will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

	Actual 2020 $000	Actual 2019 $000
Receivables from the sale of goods and services (exchange transactions)	4,406	4,808
Receivables from grants (non-exchange transactions)	0	0
Less: provision for impairment	(114)	(108)
	4,292	4,700

The ageing profile of receivables at year-end is detailed below:

	2020			2019		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Current	3,656		3,656	3,148		3,148
Past due 1 - 30 days	245		245	1,469		1,469
Past due 31 - 60 days	114		114	44		44
Past due over 60 days	391	(114)	277	147	(108)	39
Total	4,406	(114)	4,292	4,808	(108)	4,700

All receivables greater than 30 days in age are considered to be past due.

Due to the large number of other receivables, the impairment assessment is generally performed on a collective basis, based on an analysis of past collection history and write-offs.

Movements in the provision for impairment of receivables are as follows:	Actual 2020 $000	Actual 2019 $000
Balance as at 1 July	108	96
Additional provisions / (reversal)	15	53
Receivable written off	(9)	(41)
	114	108

Note 8: Investments

Investments, including those in subsidiaries, are stated at fair value. Any decreases are recognised in the Statement of Comprehensive Revenue and Expense.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expenses, except for impairment losses that are recognised in the surplus or deficit.

Term deposits with maturities less than 3 months are included in cash and cash equivalents (Note 6).
The carrying amounts of term deposits with maturities less than 12 months approximate their fair value. There is no impairment provision for term deposits.

Note 9: Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost, determined on weighted average cost basis.

Inventories acquired through non-exchange transactions are recorded at fair value at the time of acquisition.

The amount of any write-down for loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of write down.

	Actual 2020 $000	Actual 2019 $000
Held for distribution inventories		
Pharmaceuticals	289	296
Surgical and medical supplies	680	680
Main store	832	795
Other supplies	182	181
	1,983	1,952

The amount of inventories recognised as an expense during the year was $12,815k (2019: $12,797k) which included a number of expense lines in the statement of comprehensive revenues and expenses.

The net write down of inventories held for distribution amounted to ($78k) (2019: $17k). Minor variances occur throughout the year as a result of periodic stock takes.

No inventories are pledged as security for liabilities (2019: $nil). However, some inventories are subject to retention of title clauses.

Note 10: Non-current assets held for sale

At balance date there were no non-current assets held for re-sale (2019: $nil)

Note 11: Investments in subsidiaries and associates

Investment in Subsidiary

Entity	Tairāwhiti Laundry Services Limited (TLSL)
Principle activity	Partner is Gisborne Laundry Services.
Ownership interest	100%
Balance date	30 June

Financial information for subsidiary has been included in these consolidated Hauora Tairāwhiti results.

Investment in Associates

Entity	HealthShare Limited
Principle activity	Midland region DHBs shared service agency.
Ownership interest	20% (100 shares)
Balance date	30 June

Summary financial information (Hauora Tairāwhiti's share).

	Actual 2020 $000	Actual 2019 $000
Assets	7,609	5,369
Liabilities	7,092	4,862
Revenue	3,726	3,478
Surplus	88	63
Share of contingent liabilities	0	0

Entity	TLab Limited
Principle activity	Provision of laboratory services.
Ownership interest	50% (85,000 shares)
Balance date	30 June

Summary financial information (Hauora Tairāwhiti's share).

	Actual 2020 $000	Actual 2019 $000
Assets	686	575
Liabilities	224	199
Revenue	2,458	2,440
Surplus	280	262
Share of contingent liabilities	0	0

Entity	Gisborne Laundry Services
Principle activity	Provision of laundry services in Gisborne & Hawkes bay.
Ownership interest	50% (partnership via TLSL)
Balance date	30 June

Summary financial information (Hauora Tairāwhiti's share).

	Actual 2020 $000	Actual 2019 $000
Assets	346	326
Liabilities	127	199
Revenue	1,055	1,045
Surplus	390	336
Share of contingent liabilities	0	0
Total investment in associates (share of assets less liabilities)	1,198	1,010
Total share of associate results	758	661

All of the subsidiaries and associates are unlisted. Accordingly there are no published price quotations

Note 12: Property, plant and equipment

Property, plant and equipment consists of the following classes: land, buildings, clinical equipment, other equipment, information technology and vehicles.

Property, plant and equipment vested from the Hospital and Health Service.

Under section 95(3) of the NZ Public Health and Disability Act 2000, the assets of Tairāwhiti Healthcare Limited (a Hospital and Health Service) were vested in Hauora Tairāwhiti on 1 January 2001. Accordingly, assets were transferred at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts within its records. The vested assets will continue to be depreciated over their remaining useful lives.

Property, plant and equipment acquired since the establishment of Hauora Tairāwhiti.

Assets acquired by the Board since its establishment, other than those vested above and land and buildings, are recorded at cost less accumulated depreciation. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other assets classes are measured at cost, less accumulated depreciation and impairment losses.

Land and buildings are valued by an independent qualified valuer at least 3 yearly to confirm that their carrying value in the financial statements reflect their fair value. Valuations will be undertaken more regularly if necessary to ensure that no class of assets included at a valuation that is materially different from its fair value. Where fair value of an asset is not able to be reliably determined using market-based evidence, optimised depreciated replacement cost is considered the most appropriate basis for determination of fair value. Land and building revaluation movements are accounted for on a class-of-asset.

The net revaluation results are credited or debited to other comprehensive revenue and are accumulated to an asset revaluation reserve, this balance is not recognised in other comprehensive revenue but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue.

The results of revaluing land and buildings are credited or debited to an assets valuation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the Statement of comprehensive revenue and expense. Additions between revaluations are recorded at cost less accumulated depreciation.

Any gain or loss on disposal is determined by comparing the proceeds with the carrying amount of the asset and this amount is included in the net surplus or deficit.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment other than land, at rates which will write-off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

The useful lives and associated depreciation or amortisation rates of major classes of assets have been estimated as follows:

Buildings – structure	67 years	1.5%
Buildings – fit out	5 to 67 years	1.5 to 20%
Equipment	3 to 25 years	4 to 33.33%
Information Technology	2 to 12.5 years	8 to 50%
Intangible assets	3 to 12.5 years	8 to 33.33%
Motor vehicles	6.7 to 12 year	6.77 to 15%

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end. Work in progress (WIP) is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the relevant asset category on its completion and then depreciated.

	Land	Buildings	Clinical Equipment	Other Equipment	Information Technology	Vehicles	Work in Progress	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost or Valuation								
Balance 1 July 2018	2,657	48,862	17,861	1,099	2,564	2,993	1,135	77,171
Additions		1,358	1,908	30	402	1		3,699
Disposals			(934)	(83)	(536)	(1)	(571)	(2,125)
Revaluation								
Balance 30 June 2019	2,657	50,220	18,835	1,046	2,430	2,993	564	78,745
Balance 1 July 2019	2,657	50,220	18,835	1,046	2,430	2,993	564	78,745
Additions		855	1,220	54	278	1	161	2,569
Disposals			(1,112)	(14)	(2)	(1)		(1,129)
Revaluation								
Balance 30 June 2020	2,657	51,075	18,943	1,086	2,706	2,993	725	80,185
Accumulated depreciation								
Balance 1 July 2018		(13)	(11,312)	(776)	(1,401)	(2,187)		(15,689)
Depreciation expense		(747)	(1,656)	(72)	(406)	(108)		(2,990)
Elimination on disposals			934	83	536			1,554
Revaluation								
Balance 30 June 2019	0	(760)	(12,034)	(765)	(1,271)	(2,295)	0	(17,125)
Balance 1 July 2019		(760)	(12,034)	(765)	(1,271)	(2,295)		(17,125)
Depreciation expense		(767)	(1,632)	(71)	(455)	(102)		(3,027)
Elimination on disposals			1,112	14	2	1		1,129
Revaluation								
Balance 30 June 2020	0	(1,527)	(12,554)	(822)	(1,724)	(2,396)	0	(19,023)
Carrying amounts								
As at 1 July 2018	2,657	48,849	6,549	323	1,163	806	1,135	61,482
At 30 June and 1 July 2019	2,657	49,460	6,801	281	1,159	698	564	61,620
At 30 June 2020	2,657	49,548	6,389	264	982	597	725	61,162

Valuation

The most recent revaluation of land and buildings was performed by an independent register valuer, Jones La Selle, as at 30 June 2018.

Land

Land is at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unemcumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely. Restrictions on Hauora Tairāwhiti's ability to sell land would normally not impair the value because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings

Specialised hospital builldings are valued at fair value using depreciated replcement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. These include:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- Straight line depreciation has been applied in determining the depreciated replacement cost value.

Non-specialised buildings are valued at fair values using market based evidence. Market rents and capitalisation rates were applied to refect market value.

Restrictions on title

Hauora Tairāwhiti does not have full title to the Crown land it occupies, but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain lands may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975. The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of land.

Finance Leases

The net carrying amount of assets held under finance leases is $nil. (2019: $nil) for buildings and $562k (2019: $710k) for other equipment.

Note 13: Intangible assets

Acquired computer software is capitalised on the basis of costs incurred to acquire and bring to use. Ongoing staff training and maintenance are recogised as expenses when incurred.

The carrying value of an intangible assets with a finite life is amortised on a straight line basis over its useful life. The amortisation charge is recognised in the Statement of comprehensive revenue and expense.

Impairment

Property, plant, equipment and intangible assets that have a finite useful life are reviewed for impairment each year. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on one of a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used depends on the nature of the impairment and availability of information. The total impairment loss, or reversal of impairment loss, is recognised in the surplus or deficit.

	Software	FPIM Rights	WIP Software	Total
	$000	$000	$000	$000
Cost or Valuation				
Balance 1 July 2018	3,623	765	1,050	5,438
Additions	108	111	458	677
Disposals				0
Revaluation		(876)		(876)
Balance 30 June 2019	3,731	0	1,508	5,239
Balance 1 July 2019	3,731	0	1,508	5,239
Additions	19	0	726	745
Disposals				0
Impairment		0		0
Balance 30 June 2020	3,750	0	2,234	5,984

Accumulated amortisation				
Balance 1 July 2018	(2,669)			(2,669)
Amortisation expense	(289)			(289)
Elimination on disposals				0
Balance 30 June 2019	(2,958)	0	0	(2,958)
Balance 1 July 2019	(2,958)			(2,958)
Amortisation expense	(269)			(269)
Elimination on disposals				0
Balance 30 June 2020	(3,227)	0	0	(3,227)
Carrying amounts				
As at 1 July 2018	954	765	1,050	2,769
At 30 June and 1 July 2019	773	0	1,508	2,281
At 30 June 2020	523	0	2,234	2,757

Note 14: Payables and deferred revenue

Short-term payables are recorded at the amount payable.

Creditors and payables are at fair value, and subsequently measured at amortised cost using the effective interest rate method.

	Actual 2020 $000	Actual 2019 $000
Payables and deferred revenue under exchange transactions		
Creditors	3,727	2,743
Accrued expenses	13,397	8,929
Total payables and deferred revenue under exchange transactions	17,124	11,672
Payables and deferred revenue under non-exchange transactions		
GST payable	1,423	1,089
Capital Charge payable	0	0
Trusts and bequests with substantive conditions	203	164
Other	32	26
Total payables and deferred revenue under non-exchange transactions	1,658	1279
Total payables and deferred revenue	18,782	12,951

Note 15: Derivative financial instruments

Foreign exchange transactions are converted to NZ dollars at the time of payment or receipt. No derivative financial instruments have been used in the current year (2019: none).

Note 16: Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method and are classified as current unless Hauora Tairāwhiti has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Finance Leases

Leases, which effectively transfer to Hauora Tairāwhiti substantially all the risks and benefits incident to ownership of the leased items, are classified as financial leases. These are capitalised at the lower of fair value of the asset or the present value of the minimum lease payments. The leases assets and corresponding lease liabilities are recognised in the statement of financial position. The lease assets are depreciated over the period of expected benefit from their use.

Overdraft facility
Amounts drawn under the NZHPL banking facility are recorded at the amount payable plus accrued interest.

Breakdown of borrowings	**Actual 2020 $000**	**Actual 2019 $000**
Current Portion		
Finance Leases	159	148
Non-current portion		
Finance Leases	403	562
Total Borrowings	562	710
Borrowing facility Limits		
NZ Health Partnership Ltd (refer to note 6)	9,851	9,402
Total borrowing facility limits	9,851	9,402

Fair Value
The fair value of borrowings has been determined using contractual cash flow discount using a rate based on market borrowing rates. The carrying value of borrowings approximates the fair value at balance date.

Interest rate summary	**Actual 2020**	**Actual 2019**
Westpac - MRI Lease	7.14%	7.14%
NZ Health Partnership	0.00%	4.16%
Analysis of financial lease		
Minimum lease payments payable:		
No later than one year	159	148
Later than one year and not later than five years	403	562
Later than five years	0	0
Total minimum lease payments	562	710
Future finance charges		
Present value of minimum lease payments	562	710
Present value of minimum lease payments payable:		
No later than one year	159	148
Later than one year and not later than five years	403	562
Later than five years	0	0
Total present value of minimum lease payments	562	710

Hauora Tairāwhiti has entered into finance leases for MRI equipment. The net carrying amount of this equipment is included as part of Clinical equipment in Note 12.

There are no restrictions in place for any of the finance lease arrangements. These are effectively secured as the rights to the assets revert to the lessor in the event of a default in payment.

Note 17: Employee entitlements

	Actual 2020 $000	Actual 2019 $000
Current portion		
Accrued salaries and wages	3,349	2,874
Annual leave	8,658	7,450
Sick leave and shift leave	94	119
Sabbatical leave	474	459
Continuing medical education leave	1,053	905
Long service leave	661	636
Retirement gratuities	265	258
	14,554	12,701
Non-current portion		
Long service leave	567	501
Holidays Act Compliance	9,316	8,469
Retirement gratuities	393	655
	10,276	9,625
Total employee entitlements	24,830	22,326

Sabbatical Leave, long service leave, retirement gratuities and continuing medical education leave
The value of leave balances can be significantly impacted by recent earnings and are valued in line with the higher of the prior four weeks earnings, the prior 12 months earnings or the base salary. Movement in these earnings has a direct effect on the value of the overall liabilities.

The present value of sabbatical leave, long service leave, retirement gratuities and continuing medical education leave obligations included above depend on a number of factors including:

- Assessment of leave balances required based upon prior years.
- Review of the maximum potential liability in each class of leave reduced by the above.

Note 18: Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in finance costs.

Hauora Tairāwhiti has made provisions in relation to Compliance with the Holidays Act 2003 of $997k of which $150k is a current liability and $847K is a non-current liability (2019 $150k and $8,469k respectively) and in relation to treatment of Meals on Duty of Nil (2019: $630k), other minor amounts are included with Accounts payable.

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. DHB readiness and availability of resources (internal and external to the DHB) has determined when a DHB can commence the process. Hauora Tairāwhiti has assessed that further audit work is required to reach a reliable estimate of its historic non-compliance under the MOU

Notwithstanding, as at 30 June 2020, in preparing these financial statements, Hauora Tairāwhiti recognises it has an obligation to address any historical non-compliance under the MOU. The DHB has made estimates and assumptions to determine a potential liability based on its review of payroll processes for instances of non-compliance with the Act and against the requirements of the MOU.

The liability has been estimated by

- selecting a sample of current and former employees;
- Calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result across all current and former employees

This liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

Note 19: Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

	Actual 2020 $000	Actual 2019 $000
Crown equity		
Balance at 1 July	60,481	49,863
Capital contributions from the crown	20,000	11,000
Capital contributions by way of loan conversion	0	0
Repayment of capital to the crown	(382)	(382)
Balance at 30 June	80,099	60,481
Accumulated surpluses / (deficits)		
Balance at 1 July	(62,875)	(39,845)
Surplus / (deficit) for the year	(14,424)	(23,030)
Transfer from / (to) trust funds	0	0
Balance at 30 June	(77,299)	(62,875)
Revaluation reserves		
Balance at 1 July	39,004	39,004
Revaluations	0	0
Balance at 30 June	39,004	39,004
Bequest Trusts and Capital reserve		
Balance at 1 July	28	28
Interest on trust deposits	0	0
Balance at 30 June	28	28
Total equity	41,832	36,638

Included in the accumulated surpluses / (deficits) are $9,560K of funding for mental health. This accumulated total represents $317k of 2019/20 year expenditure (2018/2019: $5,426k) with the balances coming from prior years since the ring fence was established.

Trust funds and capital reserves represent the unspent portion of donations and bequests subject to restrictions. The restrictions generally specify how the donations or bequests are required to be spent in providing specific deliverables to Hauora Tairāwhiti.

Note 20: Capital commitments and operating leases

	Actual 2020 $000	Actual 2019 $000
Capital commitments	3,235	502

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

Operating leases as lessee
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are:

	Actual 2020 $000	Actual 2019 $000
Not later than one year	159	148
Later than one year and not later than five years	403	562
Later than five years	0	0
Total non-cancellable operating leases	562	710

Hauora Tairāwhiti lease a number of buildings and equipment under operating leases.
The details of the main leases are as follows:

- Tangata Rite building is on a month by month basis pending renegotiation.
- MRI equipment finance has an expiry date of 19 July 2023.

Note 21: Contingencies

Legal Proceedings
Hauora Tairāwhiti has two HDC investigations underway against it. Both actions are covered by insurance and the DHB's liability will be the amount of the excess on policy for each. (2019:$nil)

Earthquake Prone building
The Morris Adair building has been assessed as being an earthquake-prone building. Funding for the demolition of this building was announced during the 2020 financial year with demolition commencing May 2020.

Contingent assets
Hauora Tairāwhiti has no contingent assets (2019:$nil)

Note 22: Related party transactions

Hauora Tairāwhiti is wholly owned by the Crown.
Related party disclosures have not been made for transactions with related parties, including associates, that are within a normal supplier or client / recipient relationship on terms and conditions no more or less favourable than those that is reasonable to expect that a group would have adopted in dealing with a party at arm's length in the same circumstances. Further, transactions with other government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on normal terms and conditions for such transactions.

Key management personnel compensation	Actual 2020	Actual 2019
Board members	$000	$000
Remuneration	210	248
Full time equivalent members	1	1
Leadership Team		
Remuneration	3,740	4,185
Full time equivalent members	20	18
Total key management personnel remuneration	3,950	4,433
Total full-time equivalent personnel	21	19

Note 23: Board member remuneration

	Actual 2020	Actual 2019
Board Members	**$**	**$**
M Akuhata-Brown	16,559	19,320
A Cranston	7,163	0
S Faulkner	8,160	0
G Milner (Deputy Chair - Outgoing)	14,947	25,025
G Murphy (Deputy Chair)	18,282	19,070
K Ngarimu (Chair)	10,597	0
H Pihema	17,639	19,320
N Raihania	14,225	21,944
R Rauna	5,649	0
H Robertson	6,649	0
A Robinson	7,905	0
D Scott (Chair - Outgoing)	19,533	41,888
K Sheldrake	9,407	20,944
R Stoltz	9,032	20,820
J Wharehinga	17,372	19,070
B Wilson	10,632	21,120
A Wray	6,527	0
P Younger	10,041	19,382
	210,319	247,904
Māori Caucus & Community Members		
B A Clarke	1,138	2,250
J Hockey	1,750	2,000
C Johnson	1,250	1,500
L McCarthy-Robinson	3,808	5,000
Te A Nepia-Clamp	1,250	750
A Ngarangioue	500	2,500
N Ngata	0	500
M Palmer	750	500
M Para	750	2,000
N Raihania	1,274	0
H Rokx-Potae	0	2,750
C Simmonds	0	0
M Tibble	0	0
J Timutimu	500	1,750
R Waihi	1,000	1,250
J Williams	1,250	2,000
	15,220	24,750
Total governance remuneration	225,539	272,654

Hauora Tairāwhiti has provided a deed of indemnity to Board members for certain activities undertaken in the performance of the DHB's functions.

Hauora Tairāwhiti has effected Directors and officers liability and professional indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2019:$nil).

Note 24: Events after balance date

There were no significant events after balance date (2019: None)

Note 25: Financial instruments

Hauora Tairāwhiti and the Group is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, investments, debtors, creditors, and loans. All financial instruments are recognised in the Statement of financial position and all revenues and expenses in relation to financial instruments are recognised in the Statement of comprehensive revenue and expense. Except for loans, which are recorded at cost, and those covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	Actual 2020 $**000**	Actual 2019 $**000**
Fair value through surplus or deficit		
Cash and cash equivalents	207	164
Receivables	4,292	4,700
Investments in associates	1,198	1,010
	5,697	5,874
Financial liabilities measured at amortised cost		
Payables (excluding income in advance and taxes payable)	33,336	25,652
Borrowings	0	0
Finance leases	562	710
Total financial liabilities measured at amortised cost	33,898	26,362

Note 26: Risk management

Credit Risk

Is the risk that a third party will default on its obligation to Hauora Tairāwhiti, causing it to incur a loss.
Hauora Tairāwhiti is exposed to credit risk from cash and term deposits with banks (through NZHP) and receivables. For each of these the maximum credit exposure is best represented by the carrying amount in the statement of financial position.
Hauora Tairāwhiti receives the majority of income from government sources and has no significant concentration of risk from this source. It also received income from Patients, predominantly non-residents. This does present some risk to the organisation, however our credit department liaises with Immigration NZ to manage some of this risk, overall this is not significant.

Liquidity Risk

Is the risk that Hauora Tairāwhiti will encounter difficulty raising liquid funds to meet commitments as they fall due.
Hauora Tairāwhiti manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and requesting deficit support from the Ministry of Health when required.

Note 27: Capital management

Hauora Tairāwhiti's capital is its equity (Note 19) is represented its net assets.

Hauora Tairāwhiti's subject to the financial management and accountability provisions of the Crown Equities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities. Issuing guarantees and indemnities, and the use of derivatives.

Hauora Tairāwhiti has complied with the financial management requirements of the Crown Entities Act 2004 during the year. Equity is managed as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure that Hauora Tairāwhiti achieves its objectives and purpose while remaining a going concern.

Note 28: Early childhood care

Hauora Tairāwhiti receives funding from the Ministry of Education to fund part of the children's ward.

	Actual 2020 $000	Actual 2019 $000
Revenue from the Ministry of Education	57	55
Expenditure		
Personnel costs	(60)	(56)
Operation expenses	0	(3)
	(60)	(59)
Net surplus / (deficit)	(3)	(4)

Note 29: Major variations from the statement of performance expectations

Explanations for major variances from Hauora Tairāwhiti's budgeted figures in the statement of performance expectations are as follows:

Statement of comprehensive revenue and expense

Personnel Costs were over budget $1.8m or 2.11% for a variety of reasons:
A number of pay settlements above that expected were made during the year. Additional provision has been made at year end for non-compliance with the Holidays Act 2003 of $847k.

Outsourced services costs continue to be high - $3m over budget as we continue to experience difficulties recruiting and retaining skilled staff.

Non Health Board provider costs are $1.4m over budget as a result of increasing costs for Inter District Flows (IDF) outflows of $1.7m in the year.

Statement of changes in Equity

The deficit was $2.4m above the budgeted result due to the reasons given above. During the period the DHB also received deficit support equity of $20m.

Statement of financial position

Current assets are $12.2m higher than budget predominantly as a result of the receipt of $20m deficit support.
Non-current assets are $462k higher than budget mainly as a result of the capital programme.
Liabilities are $17m higher than budget due to significant increase in accruals compared to the prior year. The accruals include $1.7m for IDF outflows and sector service accruals

Note 30: New Zealand Business Number (NZBN)

Under the terms of the New Zealand Business Number Act 2016 the DHB is required to adopt and support the use of NZBN. These numbers will allow businesses to update their core information in one place and it will automatically update on other databases, especially business partners and government agencies. For the purposes of NZBN Hauora Tairāwhiti is a Tier Two agency and as such must:

- By Dec 2018 be able to identify and interact with NZBN entities without requiring any additional identifier
- By Dec 2020 be able to fully access the NZBN register

Progress to date includes working with our software suppliers to enable recording of these numbers, all DHBs are collectively working towards incorporating the NZBN within their systems.

Note 31: COVID-19 Impact

As a consequence of the COVID-19 global pandemic, in late March 2020 the New Zealand Government declared a State of National Emergency. This resulted in New Zealand entering a 4-week national lockdown. Restrictions were then gradually relaxed and from early June 2020, New Zealand moved to alert level 1. At alert level 1, there are no significant restrictions within New Zealand however there continue to be significant border controls severely limiting access into New Zealand.

We have assessed the impact of the pandemic on Hauora Tairāwhiti. We have also reviewed our financial statements on a line by line basis and made any adjustments necessary in accordance with NZ GAAP. Overall, we concluded that the impact of the COVID-19 pandemic was not material to the entity's operations or current year financial statements. The main factors contributing to this conclusion are:

- Approximately 83% of total revenue is derived from the Crown which is not considered to be at significant risk.
- Other significant sources of income including contracts with the Ministry of Health, ACC and Health Workforce New Zealand were affected to some degree. Revenue from these sources was down in the last quarter approximately 16% against the average received in the previous three quarters.
- Elective surgeries and non-acute services were not completed in the last quarter of the year to enable the DHB to cope with any COVID-19 impacts. The district was extremely fortunate to record only four cases over the entire pandemic and only one of those individuals was hospitalised for a short period of time.
- Delayed elective surgeries and non-acute services will be caught up on during 2020/21, however, it is too early to predict what impact this will have on the organisations performance overall

Management will continue to monitor the impact of the pandemic on the results of the entity and manage the business accordingly to best ensure Hauora Tairāwhiti continues to meet its financial and other objectives.